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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity for one resident (Resident #61) when a Licensed Practical Nurse (LPN) spoke rudely to the resident. The sample was 24. The census was 121.Review of the facility's Resident Rights policy dated 4/26/23, showed:-The facility shall treat residents with kindness, respect and dignity and ensure resident rights are being followed. The resident/resident representative will be informed on their rights upon admission;-Resident rights included: Respect and dignity. Review of Resident #61's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/4/25, showed:-Cognitively intact;-Diagnoses include depression and psychotic disorder. During an observation and interview on 10/1/25 at 8:32 A.M., the resident sat up in bed and drank coffee. LPN A knocked on the door, entered the room and handed the resident a medication cup. The resident took the medication and began to set the medication cup down. LPN A went to take the medication cup from the resident and the resident said he/she could take care of it him/herself. LPN A's facial expression changed, and he/she appeared irritated. He/She turned her back to the resident, started to walk away, and said in a volume easily heard and with a rude tone, see the type of attitude we have to deal with, you don't talk to us that way. He/She then exited the room and closed the door. The resident said staff can be rude. They treat him/her like he/she has dementia. He/She can do for him/herself. During an interview with the Administrator, Director of Nursing, and Corporate Administrator on 10/1/25 at 12:19 P.M., they said staff should speak to residents with respect and face the residents as they speak to them. They should not criticize. 1598315

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident's right to self-administer medications is protected if the interdisciplinary team has determined the practice is clinically appropriate for one resident (Resident #97) who had a desire to self-administer a medication and had an order to self-administer, with no assessment to ensure safe administration. The sample was 24. The census was 121.Review of the facility's Bedside Medication Storage policy, dated 12/17, showed:-Bedside medication storage is permitted for residents how wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed apocopate in the judgment of the facility's interdisciplinary resident assessment team;-A written order for the bedside storage of medication is present in the resident's medical record;-Bedside storage of medications is indicated on the resident medication administration record and in the care plan for the appropriate medications;-The resident is instructed in the proper use of bedside medications. The resident should be able to repeat the instructions or demonstrate appropriate use of the medicines. The completion of this instruction is documented in the medical record;-At least once a shift, the nursing staff check for usage of the medications by the resident. Review of Resident #97's medical record, reviewed on 9/25/25, showed:-A quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 7/5/25, showed the resident cognitively intact;-Diagnoses included chronic obstructive pulmonary disease (COPD, lung disease);-A care plan in use at the time of the investigation, showed: The resident has shortness of breath related to COPD. Goal: Maintain normal breathing pattern. Interventions included: Teach resident when to inhale and exhale while doing strenuous activities. The care plan did not address self-administration of medications;-An order dated 3/24/25, for albuterol sulfate (used to treat asthma) 2 puffs inhale orally ever 4 hours as needed for wheezing and coughing. May keep at bedside;-A progress note, dated 8/20/25, Physician G in today. New order received and noted that resident may keep albuterol inhaler at bedside;-No assessment for self-administration of medications completed. During an observation and interview on 9/25/25 at 9:11 A.M., the resident in his/her room sat on the bed. He/She had oxygen on per nasal cannula set between 2 and 3 liters. The resident said he/she wants to keep his/her inhaler at his/her bedside. The doctor had ordered him/her to have it at bedside, but staff will not give it to him/her. It is a rescue inhaler. He/She needs it at bedside because when he/she needs it, he/she needs it and cannot wait. During an interview on 9/26/25 at 9:56 A.M., the resident said he/she was still never given his/her inhaler. Staff said they have to talk to Physician G. Observation and interview on 9/29/25 at 9:32 A.M., showed the resident pulled out an albuterol inhaler from his/her bedside drawer and said staff gave it to him/her, he/she believes last Friday (9/26/25), to keep at his/her bedside. Review of the resident's medical record, reviewed on 9/29/25, showed no assessment for the resident to self-administer medications. During an interview on 9/30/25 at 8:09 A.M., Certified Medication Technician (CMT) H, the CMT assigned the resident's hall, said if a resident was able to self-administer medications, it would say on the order that the medication may be left at bedside. Typically, this is seen with inhalers or mouth rinses, etc. He/She will encourage residents to be more independent and to self-administer if they are able to. He/She will show residents proper technique and educate them on the orders. Currently, he/she does not have any resident who self-administers their medications. If a resident wants to self-administer medications, they have to go through nurse and doctor to get the order. During an interview on 9/30/25 at 12:24 P.M., the Director of Nursing said the resident had been assessed in the past to self-administer medications, but he/she was not sure if the resident was re-assessed after his/her last admission. If a resident wants to (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer a medication, staff should assess the resident for safety. If a resident has medications at the bedside, the assessment should be done.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents/and or responsible parties were notified in a timely manner when resident accounts were within $200.00 of the Medicaid limit or when the resident's account was over the Medicaid limit ($6068.80) (Residents #19, #6 and #35). The facility also failed to ensure third party liability (TPL) forms were completed for the final accounting for residents who expired, within 30 days. This affected two of three sampled residents who expired and had money in their accounts (Residents #131 and #129). The sample size was 24. The census was 121. Review of the facility's undated Business Office-Resident Trust Fund Policy and Procedure, showed:-Policy Statement: Residents of a skilled Nursing Center are to have their funds managed and personal spending money available to them. If the choice to open a trust account is made, the resident has the right to have their money safeguarded and accounted for by the Center. The Administrator ultimately will be responsible for the oversight and management of resident funds. 1. Review of Resident #19's Resident Statement Landscape, dated [DATE] at 1:12 P.M., showed a current balance of $12,161.13. Review of the resident's medical record, showed:-Payor Source-Medicaid;-No Resident Fund Balance Notification sent to the resident or resident representative as of [DATE]. 2. Review of Resident #6's Resident Statement Landscape, dated [DATE] at 1:12 P.M., showed a current balance of $8,496.39. Review of the resident's medical record, showed:-Payor Source-Medicaid;-No Resident Fund Balance Notification sent to the resident or resident representative as of [DATE]. 3. Review of Resident #35's Resident Statement Landscape, dated [DATE] at 1:12 P.M., showed a current balance of $7,460.29. Review of the resident's medical record, showed:-Payor Source-Medicaid;-No Resident Fund Balance Notification sent to the resident or resident representative as of [DATE]. 4. During an interview on [DATE] at 12:39 P.M., the Business Office Manager (BOM) said she had not sent any Resident Fund Balance Notifications when residents reached the $200.00 Medicaid limit. She is now aware the letters should have been sent and would send the letters going forward. 5. Review of Resident #131's resident fund account, showed:-Resident expired on [DATE];-A balance of $837.25 as of [DATE];-No TPL letter sent. 6. Review of Resident #129's resident fund account, showed:-Resident expired on [DATE];-A balance of $4,239.70 as of [DATE];-No TPL letter sent. 7. During an interview on [DATE] at 12:39 P.M., the BOM said TPL letters should be sent within 30 days of a resident's death. She was new to the position and would send them out within 30 days going forward. 8. During an interview on [DATE] at approximately 12:30 P.M., the Administrator said she expected Medicaid resource letters to be sent out when resident balances are within $200.00 of the resource limit. Residents are at risk of losing their benefits. She also expected TPL letters to be sent within 30 days of a resident's death.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two residents received an accurate assessment, reflective of the residents' status at the time of assessment, when the Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) was incorrectly coded that the residents received insulin. (Residents #4 and #74). The sample was 24. The census was 121. 1. Review of Resident #4's quarterly MDS, dated [DATE], showed:-Diagnoses included diabetes;-Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days: one. Review of the order summary report, dated 10/1/25, showed a physician order for Ozempic (glucagon-like peptide-1 (GLP-1) receptor agonist) subcutaneous (under the skin) solution pen injector 2 milligram (mg)/1.5 milliliter (mL), inject 2 mg subcutaneous every Saturday related to type 2 diabetes mellitus. 2. Review of Resident #75's quarterly MDS, dated [DATE], showed:-Diagnoses included diabetes;-Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days: one. Review of the order summary report, dated 9/25/25, showed a physician order for Mounjaro (GLP-1 receptor agonists) subcutaneous auto-injector pen 15 mg/0.5 mL, inject 1 application subcutaneous every Tuesday for baseline (no other information was noted). 3. During an interview on 10/1/25 at 9:25 A.M., the MDS Coordinator said Resident #4 started his/her Ozempic in August. Resident #75 was on insulin which was discontinued in March. Since then, the resident has been on Ozempic and currently has an order for Mounjaro. Ozempic and Mounjaro are not classified as insulin and should not be coded as insulin on the MDS. She expected the MDS to be coded accurately. 4. During an interview on 10/1/25 at 12:20 P.M., the Administrator said she expected insulin to be coded accurately on the MDS.

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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 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, revised 6/5/25, in use at the time of the investigation, showed:-Focus: The resident has limited mobility and requires assistance with ADL;-Goal: Will remain free of complications related to immobility, including contractures, thrombus formation, skin breakdown, fall-related injury;-Interventions: Provide supportive care assistance with mobility as needed, document assistance as needed. Observation and interview on 9/26/25 at 5:57 A.M., showed the resident sat at the side of the bed with both legs on a puddle of urine on the floor. The resident said he/she was waiting for the lady who will bring clothes and help him/her change. The blanket and bedsheets were rolled by the foot of the bed. He/She said they were soaked. The incontinence pad and middle part of the fitted sheet were soaked with urine. The resident said he/she woke up cold and wet and had been waiting for someone to help him/her all night. The call light was not within the resident's reach. He/She was confused when asked if he/she used the call light. He/She did not know what it was for. Observation on 9/26/25 at 6:06 A.M., showed CNA P entered the room and told the resident he/she was soaking wet. CNA P asked the resident to lay back down, then he/she left the room. At 6:11 A.M., CNA P returned with the resident's clothes and disposable wipes. He/She wiped the resident's buttocks and applied an incontinence brief. He/She sat the resident up on side of bed and applied a clean shirt and pants. During an interview on 9/26/25 at 6:22 A.M., CNA P said the resident was confused and does not remember using the call light. During the night shift, the residents were being checked every two hours. He/She said there were not enough staff on night shift, one CNA on one side/wing cannot do all the tasks. 3. Review of Resident #6's quarterly MDS, dated [DATE], showed:-Cognitively intact;-No behaviors;-Dependent on staff for toileting him/herself;-Always incontinent of bowel and bladder;-Diagnoses included hemiplegia and depression. Review of the resident's care plan, revised 6/5/25, in use at the time of the investigation, showed:-Focus: The resident has an ADL deficit related to hemiplegia;-Goal: The resident will maintain current level of function with ADLs through the review date;-Interventions: Does not use bed pan, toilet or commode. Utilize check and change to manage incontinency. During an interview on 9/25/25 at approximately 9:36 A.M., the resident said he/she relied on staff for everything, including toileting. Sometimes he/she was left wet after pressing the call light for assistance. It happens more during evening and night shifts. During an observation and interview on 9/26/25 at 5:30 A.M., the resident lay in bed on his/her back. The resident said he/she pressed the call light, and no one answered. He/She said he/she was soiled. An odor of urine was present in the resident's room. The resident said he/she had been waiting for an hour. The call light was not on upon arrival to the resident's room. The resident was asked to press his/her call light again at 5:31 A.M. The resident pushed the call light and said he/she was upset because this always happened at night. At 5:39 A.M., CNA I responded to the resident's call light. Observation and interview on 9/26/25 at 5:40 A.M., showed CNA I entered the resident's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room with some washcloths and an incontinence brief. When CNA I removed the brief, it was soaked with urine. CNA I wiped the resident's groin areas and buttocks with wet washcloths and applied a clean brief. The resident said it felt better after being soaked wet for a while. During an interview on 9/26/25 at approximately 5:55 A.M., CNA I said he/she was responsible for about 20 residents during the night shift. He/She would answer call lights within five minutes. Twenty residents were manageable. The resident relied on staff for all toileting needs. 4. During an interview on 9/30/25 at 7:48 A.M., Licensed Practical Nurse (LPN) O said regarding incontinence care, staff were provided in-service training a couple weeks ago. Staff had a skills day. Direct care staff were required to demonstrate providing care and they were quizzed. 5. During an interview on 9/30/25 at 12:24 P.M., the Director of Nursing (DON) said residents who are incontinent of bowel and bladder should be checked every two hours. If residents are left wet for too long, there is an increased risk of skin breakdown. If a resident was left wet long enough for the cotton on the brief to stick to the skin and to saturate the brief and bedding, that is too long. 2595043

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to adequately provide assistance to promote good nutrition. The facility identified 33 residents who received fortified foods. On one of one day of meal preparation observation, the facility failed to prepare and serve fortified food, super cereal. The facility failed to ensure one resident (Resident #11) with nutritional needs received fortified foods, health shakes and one on one meal assistance, as ordered. The sample size was 24. The census was 121.Review of the facility's Weight Variances policy, dated 3/31/21, showed:-Policy: All residents who experience significant, insidious and/or unintentional/unplanned weight loss or gain shall be assessed for nutritional status by the Registered Dietician (RD) to include but not limited to adding calorie rich/preferred snacks between meals, fortification, supplements, liberalizing diet and plan for expected weight changes. 1.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 steam table pans. The oatmeal appeared watery. A sample taste of the oatmeal showed it was thin and watery and the oats were not fully cooked. There was no flavor. A greasy feel could be detected from the added butter, but there was 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 pans with plastic wrap and placed them onto the steam table. [NAME] J did not prepare super cereal. 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 and fortified diets. No health shakes were placed on the trays. 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. Review of the facility's Fortified List, showed 33 residents who received fortified foods. 2. Review of Resident #11's current care plan, showed:-Focus: (Revised 11/6/24) The resident has nutritional problems related to impaired cognition;-Goal: The resident will maintain adequate nutritional status as evidenced by maintaining current weight with no signs and symptoms of malnutrition, and consuming meals as tolerated daily through review date;-Interventions: Administer medications as ordered. The resident needs a calm, quiet setting at meals with adequate eating time;-Focus: (Revised 1/15/25) The resident has unplanned/unexpected weight loss related to cognition;-Goal: The resident will consume 50%, two of three meals per day;-Interventions: Fortified (foods that have essential nutrients added to them to improve nutritional value of the food and help people meet their daily nutrient requirements) breakfast and provide assist with meals. Review of the monthly weight report, showed the resident's April 2025 weight was 167.8 pounds (lbs). Review of the resident's Nutritional Evaluation, dated 4/23/25, showed:-Assessment: Resident requires feeding assistance with meals;-Plan/Recommendations: Recommend fortified breakfast and double portions with meals. House shakes with meals. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/11/25, showed:-Cognitively impaired;-No rejection of care;-Required substantial/maximum assistance with eating;-Diagnoses included dementia, anxiety and Parkinson's disease (a progressive disorder that affects movement, balance and coordination). Review of the resident's physician's orders, dated (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to feed him/herself and does not require one on one feeding assistance. The resident had not received his/her breakfast tray as of 10:43 A.M. Review of the resident's Nutrition, Amount Eaten report, dated 9/30/25 at 9:00 A.M., showed the resident consumed 0-25% of his/her meal. Observation and interview on 9/30/25 at 12:04 P.M., showed CMT S and CNA R weighed the resident. The resident weighed 131.0 lbs. CNA R said the resident experienced weight loss within the last 30 days. Review of the resident's Nutrition, Amount Eaten report, for the month of September 2025, showed the resident consumed 76-100% of his/her meals 37 times and 51-75% of his/her meals 30 times. During an interview on 9/30/25 at 11:30 A.M., the Dietary Manager (DM) said fortified meals were foods with added nutritional value. Super cereal was oatmeal made with extra brown sugar, butter and milk. Super cereal was made daily, separate from regular oatmeal. When informed super cereal had not been made for breakfast on 9/26/25, she said it should have been made and served with breakfast. House shakes were in the kitchen and provided on the trays with resident meals. Dietary staff were responsible for ensuring health shakes were placed on the trays. When informed the health shakes were not passed out for residents until 9/30/25 during breakfast, she said she expected staff to pass them out, as ordered. During an interview on 9/30/25 at 11:52 A.M., the Registered Dietician (RD) said fortified foods should be made daily and served for residents with an order. Super cereal was considered a fortified food. It consisted of oatmeal with extra butter and sugar and should be made in addition to regular oatmeal. House shakes were in the kitchen and should be provided on the tray with meals. She was familiar with the resident and said he/she had an order for double portions, health shakes, a divided plate, fortified foods and assistance with all meals. Even if a resident was on hospice, the expectation was for the resident to receive the recommended diet, and for staff to feed the resident. Staff should have passed the resident a tray and assisted with feeding, or at least offered a tray to the resident. When told the resident did not receive any of the dietary recommendations, the RD said the resident had a significant weight loss and staff were expected to follow dietary recommendations. During an interview on 10/1/25 at approximately 12:30 P.M., the Administrator said she expected dietary orders to be followed. She also expected the resident to receive assistance with meals. The resident should have received a meal tray when staff passed out trays.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure residents who required tube feeding for nutrition received the feedings as ordered and received the care to prevent complications. One resident did not receive tube feeding as ordered when the pump, which was set at the correct rate, did not deliver the feeding at the correct rate. In addition, as a result of the slow infusion of formula, staff did not change the tube feeding bottle as frequently as they otherwise would have. The tube feeding hung for over 24 hours, on two different days of the five days of observation, putting the resident at risk for receiving spoiled formula (Resident #44). In addition, one resident with a history of pneumonia was provided personal care with their head lowered as the tube feeding infused, increasing the risk for aspiration pneumonia. These deficient practices affected two of three residents investigated for tube feeding care. The sample was 24. The census was 121.Review of the facility's Tube Feeding policy, dated 8/21/24, showed:-Residents with an order for tube feeding will be assessed and monitored by a registered dietician to ensure nutritional needs are being met;-Nursing will receive tube feeding order written by a physician;-The policy did not address the care required for proper tube feeding maintenance. 1. Review of Resident #44's medical record, showed:-Diagnoses included dysphagia oropharyngeal phase (difficulty or inability to move food from the mouth through the throat);-An order dated 6/11/25, for Jevity 1.5 (liquid nutrition) at 65 milliliters (ml) per hour continuous. Observation on 9/25/25 at 10:10 A.M., showed the resident lay in bed. A factory sealed 1500 ml bottle of Jevity 1.5 infused at 65 ml per hour. The bottle dated as hung on 9/24 at 7:04 P.M. and appeared to have just under the1500 ml that remained in the bottle (approximately 975 ml of formula should have been infused since the bottle was hung). At 12:24 P.M., the same tube feeding bottle hung at a rate of 65 ml per hour with 1400 ml of the formula that remained in the bottle. At 3:53 P.M., the same formula bottle hung. The tube feeding pump alarmed inactive. 1400 ml of formula remained in the bottle (approximately 1,360 ml of formula should have infused since the bottle was hung). Observation on 9/26/25 at 10:36 A.M., showed the resident lay in bed. The same factory sealed 1500 ml bottle of Jevity 1.5 that hung the day prior remained on the pump and infused at 65 ml per hour. The bottle dated as hung on 9/24 at 7:04 P.M. (over 24 hours) and appeared to have 550 ml that remained in the bottle. Observation on 9/29/25 at 7:42 A.M., showed the resident lay in bed. A factory sealed 1500 ml bottle of Jevity 1.5 infused at 65 ml per hour. The bottle dated as hung 9/28 at 9:00 P.M., with just under 1200 ml of formula that remained in the bottle (approximately 680 ml of formula should have infused since the bottle was hung). At 1:21 P.M., the same tube feeding bottle infused at 65 ml per hour with approximately 750 ml of formula that remained. Observation on 9/30/25 at 7:44 A.M., showed the resident lay in bed. A factory sealed 1500 ml bottle of Jevity 1.5 infused at 65 ml per hour. The bottle dated as hung on 9/30 at 5:30 A.M. with just under 1500 ml of formula that remained. At 1:18 P.M., the same tube feeding bottle hung on the tube feeding machine. The machine alarmed cassette error and no tube feeding infused. Approximately 1400 ml of tube feeding remained in the bottle (approximately 490 ml of formula should have infused since the bottle was hung). Observation on 10/1/25 at 8:24 A.M., showed the resident lay in bed. The same factory sealed 1500 ml bottle of Jevity 1.5 that hung over 24 hours prior remained on the pump and infused at 65 ml per hour. The bottle dated as hung on 9/30 at 5:30 A.M. with 900 ml of formula that remained (the entire bottle plus an additional approximate 250 ml of another bottle should have infused in this timeframe). During an interview on 9/30/25 at 7:48 A.M., Licensed practical Nurse (LPN) O said the resident had an issue with his/her pump this morning with being clogged. It needed to be flushed. Tube feeding bottles and tubing are (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be changed at a minimum of 24 hours, but if the bottle empties before that, staff will replace it at that time. During an interview with the Administrator, Director of Nursing (DON), and Corporate Administrator on 10/1/25 at 12:19 P.M., they said tube feeding formula should not be allowed to hang over 24 hours. Staff document on the bottle when the formula was hung. Staff should follow physician orders. 2. 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;-Diagnoses included pneumonia, stroke, and hemiplegia or hemiparesis (paralysis or weakness on one side of the body);-An order dated 9/5/25 for Jevity 1.5 at 60 ml per hour via pump, may be disconnected for up to 2 hours for care. During an observation and interview on 9/26/25 at 10:11 A.M., showed the resident lay in bed. A bottle of Jevity 1.5 infused at 60 ml per hour per his/her feeding tube. At 10:20 A.M., Certified Nursing Assistant (CNA) N entered the room to provide care. CNA N placed gloves on and lowered the resident's head of bed. The tube feeding continued to infuse. CNA N provided personal care, assisted the resident to get in a comfortable position in bed and then elevated the head of bed. Observation on 9/29/25 at 8:13 A.M., showed CNA N entered the room to provide care. The Wound Nurse entered the room for a skin assessment. CNA N placed gloves on and lowered the resident's head of bed. The tube feeding continued to infuse. CNA N provided personal care, assisted the resident to get in a comfortable position in bed and then elevated the head of bed. The Wound Nurse did not pause the feeding or direct the CNA to not lower the resident's head of bed as the formula infused. During an interview on 9/30/25 at 7:48 A.M., LPN O said when direct care staff are providing care, staff should call the nurse so the tube feeding can be put on hold during care. If this is not done the resident would be at risk of aspiration. During an interview on 9/30/25 at 12:24 P.M., the DON said if a resident is on a continuous tube feeding, CNAs should tell the nurse so they can turn the pump off if they need to provide care. Allowing tube feeding to infuse with the head of bed low is increased risk of aspiration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored appropriately. The facility identified ten medication/treatment carts and four medication rooms. Six of the ten carts and two of the four medication rooms were checked for medication storage. Issues were found in four medication carts and one medication room. Staff failed to date an opened Lispro insulin pen (fast-acting insulin used to manage blood sugar levels), to label two opened bottles of Nitroglycerin (used to treat and prevent chest pain in people with coronary artery disease) tablets, to store an opened Ensure (nutritional shakes used as meal supplement) carton with ice or refrigerate, and to make sure an opened topical cream had a cap or cover. In addition, the facility failed to label an opened Breo Ellipta inhaler (used to treat asthma) that was placed on the countertop in the medication room. The census was 121.Review of the facility's Storage of Medication policy, dated revised 11/18, showed:-Policy: medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier;-All medications dispensed by the pharmacy are stored in the container with the pharmacy label;-Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal;-Certain medications, including some multi-dose preparations, may require different dating once opened per regulations/guidelines;-When the original seal of a manufacturer's container or vial is initially broken, it is recommended that a nurse write the date opened on the medication container or vial. Review of the Ensure Plus manufacturer's website, showed, once opened, it should be refrigerated. 1. Observation and interview on 9/29/25 at 9:32 A.M., showed an undated, opened Lispro insulin pen in the top drawer of the [NAME] Hall nurse medication cart. Registered Nurse (RN) B said the medication should be dated once opened. The medication was filled on 9/26/25. RN B did not know who opened and administered the medication. 2. Observation and interview on 9/29/25 at 9:30 A.M. in the top drawer of the treatment cart on [NAME] Hall, there was one open tube of triamcinolone cream 0.1% (topical cream that relieves redness, itching and swelling) with no cap on it. RN B said the medication should have a cap on it. The cap was lost, and he/she would discard the medication. 3. Observation on 9/29/25 at approximately 10:00 A.M., showed an opened Breo Ellipta 200 microgram (mcg)/25 mcg inhaler on the countertop in the Meramec Hall medication room, without a label showing who the medication belonged to. 4. Observation and interview on 9/29/25 at 10:10 A.M., the Missouri Hall treatment cart had one bottle of Nitroglycerin 0.4 milligram, without a label showing who the medication belonged to. Licensed Practical Nurse (LPN) C said he/she did not know who the medication belonged to, and all medications should have a label with the resident's name and expiration date on it. 5. Observation on 9/29/25 at 10:35 A.M., the [NAME] Certified Medication Technician (CMT) medication cart had one bottle of Nitroglycerin 0.4 milligram with no name on the medication, in the top drawer. There were several cartons of Ensure Plus in the drawer, one carton was open and was not on ice. CMT D said he/she did not know who the nitroglycerin belonged to. He/She opened the Ensure Plus today and he/she would dispose of it. 6. During an interview on 9/30/25 at 12:21 P.M., the Director of Nursing (DON) said the staff should label and date all opened medications. Opened topical creams should be capped and stored properly. The Ensure drinks should be refrigerated or placed in ice after opening.

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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. **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 (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 fresh fruit and a small salad with one slice of tomato and one slice of onion. Observation and interview on 10/1/25 at 9:34 A.M., showed the resident in his/her room with his/her breakfast tray. The resident was served bacon and two eggs. He/She said the breakfast is the same every day. He/She is supposed to get fresh fruit, and he/she does not. It even shows it on the meal ticket. Most days he/she gets no fresh fruit. During an interview on 10/1/25 at 12:19 P.M., with the Administrator, Director of Nursing (DON) and Corporate Administrator, they said meal tickets preferences should be followed when able. There is always fresh fruit on hand. The resident wants a lot of fresh fruit. He/She will go down to the kitchen and get it when he/she wants it. 1598315

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	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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prepare foods by methods that conserve nutritive value, flavor, and appearance. In addition, the facility failed to ensure food was palatable for one of two sample trays tested. Residents interviewed reported concerns with the palatability and flavor of food (Residents #4, #61, #75, #118, and #6). The sample was 24. The census was 121.1. During an interview on 9/26/25 at 10:11 A.M., 10 residents who represent the resident council, said the food is terrible. Sometimes it is so bad you cannot eat it. The fried eggs are hard. The oatmeal is bad. They put dislikes on their meal tickets but are still served those items. During an interview on 9/30/25 at 1:49 P.M., Activity Aid M said the residents at the resident council meetings frequently complaint about the food taste and not being offered any condiments that would help with food taste. 2. Observation on 9/26/25 at 5:15 A.M., showed [NAME] J made pureed eggs. He/She placed cooked scrambled eggs and a few hardboiled eggs into a blender. He/She then added hot water and blended the eggs. He/She poured the puree out in a steam table pan. It appeared thick and slightly chunky. A tasted sample of the pureed eggs showed it tasted bland and watered down and had a gritty/[NAME] texture. Observation on 9/26/25 at 6:41 A.M., showed [NAME] J put quick rolled oats into a 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. Observation on 9/26/25 at 9:22 A.M., showed breakfast meal service finished. No salt or sugar was provided on any of the trays sent out. A test tray sampled at that time included a fried egg, sausage, oatmeal, 2 pieces of bacon, French toast and a pancake. The oatmeal had no flavor. One of the pieces of bacon was cooked through but the second piece of bacon was flimsy and rubbery, no crunch, the fat not rendered. 3. Review of Resident #4's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/11/25, showed the resident cognitively intact. During an interview on 9/25/25 at 9:27 A.M., the resident said there are food issues at the facility, specifically taste. The food does not taste right. It is hit and miss. if you do not like what is served, they will offer things like hot dogs. 4. Review of Resident #61's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 10/1/25 at 8:27 A.M., the resident said the resident council had been trying to get creamer, coffee, sugar, and condiments for their food sent with the trays, but dietary does not send it up with the trays and nursing staff said they do not have any on the floor, so residents are not given these with their meals. The food tastes bad. Some of the food that he/she is served is too hard to eat. Carrots are not cooked right. The scalloped potatoes are hard as a rock. Residents have so much trouble getting coffee and have to beg for sugar and creamer. The facility does keep coffee and creamer on the first floor, but it does not come up to the second floor. Staff should be offering condiments. At the resident council meetings residents complain but nothing changes. 5. Review of Resident #75's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 9/29/25 at 9:10 A.M., the resident said he/she never finished his/her meal because the food was nasty at all meals. 6. Review of Resident #118's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 9/25/25 at approximately 9:36 A.M., the resident said the food was gross. The facility will (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	offer alternatives, but the alternatives were not good either. He/she has expressed his/her concerns about the food. 7. Review of Resident #6's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 9/25/25 at approximately 9:40 A.M., the resident said the food was horrible. He/she received options and choices, but the taste was horrible. 8. During an interview on 9/30/25 at 11:30 A.M., with the DM and Administrator, the DM said food should food be flavorful and appetizing. Dietary staff should add butter, milk, and brown sugar to the oatmeal for the residents with fortified foods, this is also called super cereal. Regular oatmeal does not get anything in it. If a resident wants something for their oatmeal, dietary will send condiments to them. The Administrator said all the oatmeal should be super cereal. When cooking bacon, the bacon should be cooked through and fat rendered. 9. During an interview on 9/30/25 at 11:52 A.M., the Dietician said super cereal should get butter and brown sugar added. Other residents can add butter or sugar depending on what they request.

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to serve residents a nourishing snack at bedtime when the time between meals was more than 14 hours. This had the potential to affect all residents (including Residents #61, #24, #36 and #4), who ate from the facility kitchen. The sample was 24. The census was 121.Review of the facility's Meals and Snacks policy, dated 3/31/21, showed:-Meal service shall be provided to residents on a regularly scheduled basis according to facility established times. Nutritional services shall be responsible for all food preparation including snacks and shall deliver meals to the residents or the nursing units. Snacks shall be delivered to the nursing units by nutritional services personnel. Nursing shall be responsible for distributing snacks to the residents;-Mealtimes shall be scheduled to ensure a maximum of 14 hours from dinner to breakfast on the following day;-The policy failed to address the requirement for a substantial snack delivered at bedtime when there are more than 14 hours between meals. 1. Review of the facility's mealtimes and location list, showed on Carondelet, [NAME], [NAME], Missouri, and Meramec:-Breakfast 8:00 A.M. to 9:30 A.M.;-Lunch 12:00 P.M. to 1:30 P.M.;-Dinner 5:00 P.M. to 6:30 P.M.;-Lafyette hall not listed;-15 hours between the dinner and breakfast meal service. Observation of meal service on 9/25/25, showed meals served during the scheduled mealtimes:-At 12:41 P.M., lunch trays arrived to [NAME];-At 5:45 P.M., dinner trays were already delivered, and residents ate dinner on the second floor ([NAME] and Lafyette). Observation of meal service on 9/26/25, showed meals served during the scheduled mealtimes. At 5:04 A.M., [NAME] J arrived for meal prep. At 7:28 A.M., [NAME] J began dishing food onto trays as dietary staff loaded them into carts. The first cart left the kitchen at 7:49 A.M. At 9:22 A.M., the last tray left the kitchen. Observation of meal service on 9/29/25, at 8:46 A.M., showed hall trays delivered to the Missouri hall, served during the scheduled mealtimes. Observation of meal service on 9/30/25, showed meals served:-At 8:59 A.M., breakfast trays arrived 2nd floor ([NAME] and Lafyette), served late;-At 1:20 P.M., lunch trays arrived at the Carondelet Hall during scheduled mealtimes. During an interview 9/25/25 at 12:45 P.M., the Dietary Manager said breakfast prep starts at 5:00 A.M. and served at 7:30 A.M. Right after breakfast the cook starts lunch prep, and lunch is served at 11:30 A.M. Evening dietary staff come in at 12:00 P.M. for dinner prep and dinner is served at 4:30 P.M. 2. Review of the Resident Counsel minutes, dated 7/9/25, showed snacks not being given out. Department responses: food is appropriate temp when leaving the line. Will make prompt change to get food to halls faster and get with nursing to serve faster. Review of the Resident Counsel minutes, dated 9/10/25, showed residents not receiving what they are ordering, no snacks, beverages not on trays. Department response: I will in-service staff on customer service, advise residents to call front desk in the event they do not get through to the kitchen, and will send a variety of snacks each night. During an interview on 9/26/25 at 10:11 A.M., 10 residents who represent the resident council said bedtime snacks are left at the nurse's station. Staff do not pass snacks, unless someone asks for snacks. One resident said he/she did not even know the facility had snacks. During an interview on 9/30/25 at 1:49 P.M., Activity Aide M said during the resident council meetings, residents frequently complain that breakfast is served late. They say they are not getting their eve snack. The snacks are not being offered and/or provided when requested. 3. Review of Resident #61's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 9/4/25, showed the resident cognitively intact. During an interview on 10/1/25 at 8:27 A.M., Resident #61 said dinner is usually served (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by 5:00 P.M., but sometimes as late as 5:20 P.M.; however, yesterday it was served at 6:30 P.M. He/She never gets snacks in the evening or at bedtime except for 3 nights ago, someone came around and offered snack cakes or chips. That was the first time in months he/she was offered a snack in the evening. He/She had been told in the past there are snacks on the nurse's desk and the residents have to get them ourselves. He/She had never been offered something like a sandwich. He/She would probably be interested in a sandwich at times, especially if dinner was early or if he/she did not eat a lot. 4. Review of Resident #24's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 9/29/25 at 9:17 A.M., the resident said breakfast will sometimes come as late as 9:30 A.M. or 10:00 A.M. It is too long between meals. There are no stacks offered at night. There are stacks at the nurse's station if residents want to ask. They have cookies and other snacks like that, but nothing substantial. On 9/30/25 at 1:17 P.M., the resident said he/she was never told that he/she could have a sandwich at bedtime. That is something he/she would be interest in. Tonight, he/she will ask for one. During an interview on 10/1/25 at 8:22 A.M., the resident said he/she asked for a sandwich last night and staff said he/she already had dinner. He/She was not provided with a sandwich. 5. Review of Resident #36 quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 9/30/25 at 10:36 A.M., the resident said staff do not serve evening snacks. Sometimes they offer chips, just snacks, and nothing substantial. He/She will sometimes go up to 16 hours without food. Breakfast usually comes around 8:00 A.M. 6. Review of Resident #4's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 9/29/25 at 9:38 A.M., the resident said dinner is served by 6:00 P.M. In the evenings, sometimes he/she gets a snack and sometimes not. Staff are given snacks from the kitchen before kitchen staff leave, but staff do not always pass it out to the residents. The snacks consist of cookies and snack cakes, nothing substantial or healthy. During an interview on 10/1/25 at 9:23 A.M., the resident said he/she asked staff for a sandwich last night and staff said now you know they didn't send any sandwiches up here, we are lucky if we get snacks sent. 7. During an interview on 9/30/25 at 11:30 A.M., with the Dietary Manager (DM) and Administrator, the DM said in the evenings, residents get sandwiches, chips, [NAME] butters bars, and honeybuns. Dietary will deliver it to the nurse's station. Nursing staff will be responsible for passing the food. Sandwiches are placed in the resident refrigerator on the first floor. Observation on 10/1/25 at 9:36 A.M., of the clean utility room that contained the resident refrigerator, showed a 3-shelf refrigerator. The entire top and middle shelf full of lunch bags, sodas, and grocery bags. The bottom shelf was half full with grocery bags and Tupperware containers. The available shelving was an area approximate 8 inches by 12 inches. No sandwiches were in the refrigerator. 8. During an interview on 10/1/25 at 11:38 A.M., the Dietician said if there are more than 14 hours between dinner and breakfast, she would expect a substantial snack to be offered at bedtime. A substantial snack could be something like a fruit cup, yogurt, cookies and a sandwich. He/She talked with the DM yesterday and was told that there are not more than 14 hours between meals, and that the mealtime list provided was not correct. The DM told her she provides the residents with things like [NAME] butter bars and chips. She did not mention sandwiches.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store and prepare food in accordance with professional standards for food safety and facility policy on three of three days of observation. The facility failed to ensure the hot water in the hand washing sink was functional and failed to ensure staff washed their hands after touching their face mask, personal phone and other potentially unclean surfaces. Staff failed to clean food debris from the floors, dish washing 3-vat sink, equipment, and food preparation surfaces. Staff stored dried goods with no lids or the lids opened. In addition, drinks and other liquids were spilled in the dry storage room and not cleaned for all three days of observation. This had the potential to affect all residents who ate from the facility kitchen. The census was 121.1. Review of the Department of Health - City of [NAME] hand washing sign, posted at the handwashing sink, showed handwashing is done after handling garbage; before handling food; anytime you change tasks; after handling dirty dishes, utensils, or equipment; after taking off or putting on gloves; after touching your face, hair, or clothing; after using the bathroom; after eating or drinking; and, after coughing or sneezing. Review of the Hand Sink Proper Hand Washing Procedure sign, posed at the handwashing sink, showed:-Wet your hands with hot running water;-Apply soap;-Rub your hands together for at least 20 seconds;-Clean under fingernails and between fingers;-Rinse hands thoroughly under running water;-Dry hands. 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 showed the resident trays set out on the carts with utensils, napkins, and resident diet tickets. [NAME] J put on gloves and did not wash his/her hands. The surveyor washed his/her hands at the handwashing sink. The water ran for approximately 2 minutes and it did not get hot. [NAME] J said he/she had no idea if the water at the handwashing sink got hot. [NAME] J began meal preparation. He/She placed cooked eggs, some hardboiled and some scrambled eggs in a blender and made pureed eggs. He/She then covered the pureed eggs with plastic wrap. He/She changed his/her gloves and placed the dirty blender into the middle vat of the 3-vat sink and ran hot water over the dish. He/She then removed his/her gloves, and without washing his/her hands, walked into the walk-in cooler and came out with a box of individual serving sized butter. [NAME] J placed butter on each meal tray. He/She then picked up a butter container that had fallen on the floor and held it in his/her ungloved hand as he/she returned the box of butter to the walk-in cooler. He/She then exited the walk-in cooler with the butter that had fallen and bread. He/She placed the butter in the trash and placed gloves on. He/She did not wash his/her hands. He/She placed a toaster on the back wall preparation station, took two pieces of bread out of the bread bag and placed them in the toaster. [NAME] J got pre-cooked hardboiled eggs from the walk-in cooler, pleased them in a large pan on the stove, and added hot water from the coffee maker before turning on the oven. He/She removed his/her gloves and placed new gloves on. He/She then took the toasted bread from the toaster and placed it on a tray and put more bread in the toaster. [NAME] J continued to prepare the breakfast meal. Further on in the observation, [NAME] J removed his/her gloves, walked over to the mixer that sat in the 3-vat sink, placed gloves on and washed the blender with dish soap and hot water. He/She changed his/her gloves and did not wash his/her hands. He/She took the blender to the back food preparation area and made pureed sausage with pre-cooked sausage. Once done, he/she placed the blender in the middle vat of the 3-vat sink and ran hot water over it. He/She covered the pureed sausage with plastic wrap and placed in a warming cart. He/She continued (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with meal preparation. At 5:52 A.M., someone knocked at the kitchen door. [NAME] J answered the door, got a metal tub from the clean dish rack in the back and handed it to the person at the door. He/She removed his/her gloves and did not wash his/her hands, placed new gloves on and continued with meal preparation. At 6:11 A.M., Dietary Aide (DA) L arrived through the back door with his/her bag and phone in hand. He/She wore a face mask over his/her mouth. He/She placed his/her cell phone down on a serving cart and returned to the back area where the lockers are. He/She returned and washed his/her hands. After washing his/her hands, the temperature of the water was tested and felt cold to the touch. DA L picked up his/her cell phone and placed it on the back food preparation station. He/She then got a hair net and put it on. The kitchen phone rang. DA L pulled his/her facemask down to his/her chin and picked up the phone. After the call, he/she walked over and without washing his/her hands or placing gloves on, began to pull trays out of the carts and read the name cards. Once he/she found the intended tray, he/she grabbed it and placed it on the steam table. He/She grabbed an individual serving sized syrup, placed it on the tray, told [NAME] J that the resident needed their tray by 7:00 A.M. and walked into the walk-in cooler. He/She returned with a juice and placed it on the tray. He/She then pulled his/her mask up over his/her mouth and walked out of the kitchen. At 6:22 A.M, more staff began to arrive to help with meal service. At 6:24 A.M., DA L returned to the kitchen and washed his/her hands in the hand washing sink. Once done, the water was checked and felt cold to the touch. He/She placed gloves on and began helping with meal preparation. A little later in the observation, DA L, with no gloves on, placed syrup on the trays. He/She adjusted his/her facemask and then continued to place syrup on the trays. He/She then walked over to the dish drying racks, pulled his/her mask down under his/her chin and began to sort through the stacks of cups. He/She then placed gloves on without washing his/her hands and began to pass out bowls of cereal. Observation and interview on 9/29/25 at 7:23 A.M., showed meal service in progress in the kitchen. The surveyor allowed the handwashing sink to run for approximately 2 minutes. The water felt cold to the touch. [NAME] K said there was an issue with the hot water at the hand washing sink. The water heater clicks off at times. He/She thinks it is fixed now. During an interview on 9/29/25 at 7:28 A.M., the Administrator said no one had reported issues with the hand washing sink not getting warm. During an interview on 9/29/25 at 9:19 A.M., the DM said staff wash their hands when they first arrive at the kitchen and anytime hands get soiled. The issue with the hot water in the handwashing sink just started. Maintenance was just made aware of the issue today. During an interview on 9/29/25 at 10:11 A.M., the Maintenance Supervisor said he was told today about the water in the handwashing sink not getting hot. He had not investigated the cause yet. At 1:51 P.M., the Maintenance Supervisor said the water is fixed. Someone had turned the hot water valve handle, and it was not all the way on. During an interview on 9/30/25 at 11:30 A.M., with the DM and Administrator, the DM said staff should wash their hands when they first arrive to the kitchen, when they change their gloves, and after touching a mask or their phone. Staff should not put their phones on the food preparation stations. 2. Review of the facility's Nutritional Services Sanitation policy, dated 3/31/21, showed:-Nutritional services shall ensure a clean and sanitary work environment; to promote and protect food safety; and, to maintain compliance with Federal, State and local regulations governing food sanitation and safety;-Personnel shall be responsible for daily, weekly, and monthly cleaning assignments as determined by the dietary manger and/or his/her designee;-Cleaning assignments may include but not limited to equipment, storage areas, walls, and food service-related carts. 3. Review of the facility's Ware Washing policy, dated 3/31/21, showed:-Nutritional services employees shall ensure food is prepared and served in clean food-safe supplies and maintain compliance with Federal, State, and local regulations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	governing food safety;-Tableware and supplies shall be washed and sanitized according to food safety practices and regulatory guidelines as follows: All tableware, utensils, preparation, and service supplies shall be washed and sanitized in the pot sink and/or through use of a commercially approved dish machine;-The pot sink shall be a three sink unit with a detergent in the first sink, a clear rinse water in the second, and a sanitizer in the third and final sink. Pots and pans washed in the pot sink may be sanitized in the dish machine;-The dish machine shall be emptied and cleaned after each meal, then refilled, as appropriate. 4. Review of the facility's Daily Kitchen Checklist, dated 9/22/25 though 9/28/25 that hung on the pin board near the Dietary Manager's office, reviewed on 9/29/25 at 7:28 A.M., showed use N/A when the item is not applicable. Do not leave blank. Use W/O when work order is pending. Do not leave blank:-All dishes, pots, pans, and utensils are cleaned and stored properly after each meal and snack:--Initialed as completed on Mon 9/22, Sat 9/27, and Sun 9/28. All other dates blank;-All sinks are cleaned and sanitized after use:--Initialed as completed on Mon 9/22, Sat 9/27, and Sun 9/28. All other dates blank;-All work counters/tables are cleaned and sanitized after use:--Initialed as completed on Mon 9/22, Sat 9/27, and Sun 9/28. All other dates blank;-Steam table is cleaned and sanitized after each use:--Initialed as completed on Mon 9/22, Sat 9/27, and Sun 9/28. All other dates blank;-Floors swept and mopped daily:--Initialed as completed on Sat 9/27 and Sun 9/28. All other dates blank;-Store room floors, shelves, and area cleaned and tidied up daily;--Initialed as completed on Mon 9/22. All other dates blank;-Clean steamer and steam table after each use:--Initialed as completed on Sat 9/27 and Sun 9/28. All other dates blank. 5. Review of the facility's Weekly Kitchen Checklist, dated 9/22/25 though 9/28/25 that hung on the pin board near the Dietary Manager's office, reviewed on 9/29/25 at 7:28 A.M., showed:-Clean pantries, shelves, and food canisters: Documented as completed on 9/24/25;-Deep clean ovens weekly or as needed: Not documented as completed;-Polish all stainless-steel surfaces: Not documented as completed;-Deep fryer cleaned and oil changed weekly, or as needed: Not documented as completed. 6. Review of the facility's Monthly Kitchen Checklist, dated September, that hung on the pin board near the Dietary Manager's office, reviewed on 9/29/25 at 7:28 A.M., showed:-Underneath all prep stations deep cleaned: Not documented as completed;-Floors deep cleaned: Not documented as completed;-Underneath cook's area deep cleaned. Not documented as completed. 7. Observation during the initial brief kitchen tour on 9/25/25 at 8:30 A.M., showed meal service in progress:-The kitchen floor with dirt and debris;-The dry storage room with a single serving juice cup on the ground between two storage racks and a liquid spilled out from around it. The spill looked partially dried. Along the wall on the right side of the dry storage room, an oily spill under the dry storage rack. To the right of the door to the dry storge room, a dried and sticky spill on the ground. Review of the facility's menu showed:-Cheeseburger on a bun, lettuce, tomato and pickle served for the dinner meal on 9/24/25; -Tater tots served for the dinner meal on 9/25/25. Observation of breakfast meal service on 9/26/25 at 5:04 A.M., showed:-The kitchen floor with dirt and debris;-The dry storage room with a single serving juice cup on the ground between two storage racks and a dried liquid spilled out from around it. Along the wall on the right side of the dry storage room, an oily spill under the dry storage rack. To the right of the door to the dry storge room, a dried and sticky spill on the ground;-Behind the oven an opened individual serving jelly container lay on the ground;-A two-tier stainless-steel rolling cart near the dish washing sink with a tater tot on the bottom tier;-Dirty dishes sat in the dish washing station with food debris caked on. [NAME] J said the dishes were from the prior day;-Under the 3-vat sink, the floor sticky. A medium sized pieces of cardboard that appeared wet with an opened individual sized serving butter container and food debris on top;-A flour and sugar bin sat on the floor in the back (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	food predation station. The binds covered on top and on the sides with drips and greasy smears. The sugar container with 4 large drips of what appeared to be dried puree food on the top;-A two-tier stainless-steel table in the back serving area with rusty spots on the bottom tier with the stainless steel finish missing. Dried on food drips and greasy spills cover the bottom tier and along the sides. Clean muffin pans and a cutting board stored on the bottom shelf;-Behind the ice machine, a large amount of debris and trash lay on the ground, with a build-up of a black, thick substance. A leak from the ice machine and a puddle on the ground. The wall behind the ice machine appeared to be swollen and wet, with a hole in the wall with a dark colored, fuzzy substance on the wall;-Under the dishwashing sink, an opened single serving peanut butter container lay on the ground next to some crinkled up plastic wrap;-The 3-vat sink against the wall near the dishwashing station. The basin to the right labeled wash, the middle basin labeled rinse, the basin to the left labeled sanitize. Inside the sanitize basin, a large amount of what appeared to be meat cuttings and other food debris dried to and caked onto the bottom and sides of the basin. The wash basin wet and appeared to be recently used. Soapy suds on the bottom of the basin. At 5:47 A.M., a baby roach crawled across the shelf above the 3-vat sink;-A food warmer, located near the deep [NAME], with a greasy build-up along the bottom lip and grease splashes across the front. The greasy build-up filled the bottom lip that appeared to be approximately a quarter inch deep and half inch wide on the side closest to the deep [NAME]. The side of the [NAME], near the deep [NAME], had a large amount of greasy splatters with food debris stuck to the splatters;-The deep [NAME] with food debris and crumbs along the edges, sides, and top. Food debris floated on the top of the grease;-The floor around the deep [NAME] with a thick greasy build-up with dirt and debris stuck to the grease;-The front of the steam table, with a dead roach that lay on the bottom shelf next to clean dishes. A second dead roach a few inches away. Under the steam table in front of the [NAME], a paper towel appeared greasy and stuck to the bottom shelf;-A build-up of debris under the serving station/steam table;-In the dish washing sink in the dish washing station, the sink with dried food, to include pickles, onions, strawberries, greens, and other food debris;-A square drain on the floor near the 3-vat sink with a metal cover with food debris caked around the edges. A roach crawled out of the drain and crawled to the back food preparation station;-Under the stove, napkins, plastic wrap, food debris and a build-up of dirt. A large roach crawled out from under the stove and crawled under the steam table. Observation on 9/29/25 at 7:16 A.M., showed:-The kitchen floor with dirt and debris;-The dry storage room with a single serving juice cup on the ground between two storage racks and a dried liquid spilled out from around it. Along the wall on the right side of the dry storage room, an oily spill under the dry storage rack. To the right of the door to the dry storge room, a dried and sticky spill on the ground;-The 3-vat sink against the wall near the dishwashing station. A dead roach lay inside the wash basin;-A two-tier stainless-steel table in the back serving area with rusty spots on the bottom tier with the stainless-steel finish missing;-Behind the ice machine, a large amount of debris and trash lay on the ground, with a build-up of a black, thick substance. A leak from the ice machine caused a puddle on the ground. The wall behind the ice machine appeared to be swollen and wet, with a hole in the wall with a dark colored, fuzzy substance on the wall;-A roach smashed on the ground in front of the steam table;-A food warmer, located near the deep [NAME], with a greasy build-up along the bottom lip and grease splashes across the front. The greasy build-up filled the bottom lip that appeared to be approximately a quarter inch deep and half inch wide on the side closest to the deep [NAME]. The side of the [NAME], near the deep [NAME], with a large amount of greasy splatters with food debris stuck to the splatters;-The deep [NAME] with food debris and crumbs along the edges, sides, and top. Food debris floated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on the top of the grease;-The floor around the deep [NAME] with a thick greasy build-up with dirt and debris stuck to the grease;-The front of the steam table, with a dead roach that lay on the bottom shelf next to clean dishes. Under the steam table in front of the [NAME], a paper towel appeared greasy and stuck to the bottom shelf;-A build-up of debris under the serving station/steam table;-A square drain on the floor near the 3-vat sink with a metal cover with food debris caked around the edges. During an interview on 9/29/25 at 7:23 A.M., [NAME] K said he/she has seen some roaches but not too bad. There is a daily cleaning list. [NAME] K pointed to the pin board near the dietary manager's office and said staff sign off when a task is done. In the evening, after dinner, staff wash all the dishes. The cook does a walk around to ensure the dishes are done. During an interview on 9/29/25 at 7:31 A.M., the Administrator said there is a cleaning schedule hanging on the wall near the dietary manager's office that staff sign when a job is done. During an interview with the DM, completed during a walkthrough of the kitchen on 9/29/25 at 9:19 A.M., the DM said the deep [NAME] is cleaned once a week. The day of week this is done differs. Typically, it is cleaned on Thursday or Friday. [NAME] K said he/she changed the [NAME] oil two Fridays ago. The DM said the other cook should have changed it then on this last Friday. When cleaning the friers, they drain the oil and clean all the debris and run hot soapy water through it. The spatters and food debris on the heating tray is cleaned up after lunch, daily. They do wash dishes in the 3-vat sink. Food debris should be cleaned up immediately out of the sink. On Friday 9/26/25, the sink was dirty because staff left the food debris overnight and they should have cleaned it before they left. Kitchen closing duties include to clean up all the food debris before leaving for the day. The cardboard under the sink should be cleaned up. That was there when they replaced the tubing under the skin. It was done a while back, not sure when. Once a week the floor in the dry storage room should be cleaned. If there is a spill, it should be cleaned immediately. Observation showed the juice cup that was on the floor was now sitting on the food storage shelf. The three spills remained. The DM picked up the empty juice cup and said she would throw it away. Observation showed a dead roach on the steamtable shelf. The DM and she said this should be cleaned up. Observation showed debris and build-up behind the ice machine. The DM said the debris behind the ice machine should be cleaned up every day. It should be cleaned under and behind the equipment every day. 8. Observation on 9/25/25 at 8:30 A.M., in the back preparation station, showed:-A container of fajita seasoning, sat on a shelf opened;-A container of ground thyme leaves, sat on a shelf opened;-A large tub of parsley flakes with no lid. Observation on 9/26/25 at 5:04 A.M. and 5:20 A.M., in the back preparation station, showed:-A container of fajita seasoning, sat on a shelf opened;-A container of ground thyme leaves, sat on a shelf opened;-A large tub of parsley flakes with no lid;-A container of rotisserie seasoning, sat on a shelf opened;-A container of black pepper, sat on a shelf opened;-A container of salt, sat on the counter, with the lid propped opened;-The sugar bin that sat on the floor, with the lid propped opened. During an interview on 9/29/25 at 9:19 A.M., the DM said she is not sure where the lid to the parsley flakes is. Seasoning should be closed after use. During an interview on 9/30/25 at 11:30 A.M., with the DM and Administrator, the DM said the sugar and salt bin lids should be closed when not in use.

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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 acceptable infection control standards when staff failed to follow the facility's policy to use appropriate technique and hand hygiene during incontinence care (peri-care, cleansing the genitals and anal area) for 5 out of 5 residents observed (Residents #10, #59, #6, #117 and #69). The staff also failed to wear a gown when providing high contact care for residents on Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for 5 out of 6 residents observed (Residents #6, #117, #69, #75 and #57). The sample was 24. The census was 121.Review of the facility's Hand Hygiene policy, dated 4/28/22, showed:-The facility will provide guidelines to employees on proper handwashing and hand hygiene techniques that will aid in the prevention of the transmission of infections;-Handwashing: Employees will perform handwashing with soap and water when hands are visibly soiled;-Hand Sanitizer: Employees may use an alcohol-based hand rub when hands are not visibly soiled. 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;-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. Review of the facility's EBP, policy dated 5/15/24, showed:-Policy: the facility may expand the use of Personal Protective Equipment (PPE) & refer to the use of gowns & gloves during high-contact resident care activities that provide opportunities for transfer of MRDOs to hands/clothing. The use of gown & gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for facility residents with wounds and/or indwelling medical devices regardless of [NAME] colonization as well as for residents with [NAME] infection/colonization;-Examples of High-Contact Resident Care Activities requiring Gown & Glove Use for EBP: Dressing; Transferring; Providing Hygiene; Changing Briefs or Toileting; and, Wound Care: Skin Opening requiring a dressing;-Post signage on the door/wall outside of the resident's room indicating the use of EBP;-Post signage in the resident room with information on use of EBP & required PPE (e.g., gown & gloves). Enhanced Barrier Precautions signage should include information on high contact resident care activities that require the use of gown & gloves. 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: Activity of daily living (ADL) self-care performance deficit;-Goal: Maintain current level of function with ADLs;-Interventions included: Personal hygiene care: Dependent on staff. During an observation and interview on 9/26/25 at 10:11 A.M., the resident's spouse said the resident needs 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). CNA N said he/she likes to double glove because sometimes a glove will get a hole in it. The resident's spouse assisted CNA N to unsecure the residents brief and help to position the resident into the bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 visible on the resident's skin. CNA N cleansed the stool from the resident's skin and then removed one pair of gloves, leaving the other on. He/She did not perform hand hygiene. He/She applied barrier cream to his/her left gloved hand and applied the cream to the resident's buttocks area. While wearing the same gloves used to apply barrier cream, CNA N then applied a clean brief and adjusted the resident's pillow while he/she wore the same soiled gloves. 2. Review of Resident #59's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment; -Dependent on toilet hygiene;-Frequently incontinent of urine and bowel;-Diagnoses included Parkinson's disease, heart failure, and history of hip fracture. Review of the resident's care plan, revised 6/5/25, in use at the time of the investigation, showed:-Focus: The resident has limited mobility and requires assistance with ADLs;-Goal: Will remain free of complications related to immobility, including contractures, thrombus formation (blood clot), skin breakdown, fall-related injury;-Interventions: Provide supportive care assistance with mobility as needed, document assistance as needed. Observation and interview on 9/26/25 at 5:57 A.M., showed the resident sat at the side of the bed with both feet on a puddle of urine on the floor. The resident said he/she was waiting for the staff who will bring clothes and help him/her change. The blanket and bed sheets were rolled by the foot of the bed. He/She said they were soaked. The incontinence pad and middle part of the fitted sheet were soaked with urine. The resident said he/she woke up cold and wet and had been waiting for someone to help him/her all night. Observation on 9/26/25 at 6:11 A.M., showed CNA P entered the room to provide care. The resident lay on the bed. The CNA brought the resident's clothes and a pack of wet disposable wipes. After applying gloves, he/she unfastened and placed the soiled brief under the resident. The resident then pulled the brief from under him/her and gave it to the CNA. He/She placed the brief in the trash bin. The CNA asked the resident to roll on the side, facing the wall. Without changing gloves, CNA P pulled 2 disposable wipes and wiped the resident's buttocks, once on each side. He/She then applied the clean brief on without cleaning the front genital area and the anal area. He/She put the resident's pants on, then assisted him/her to sit up on the side of bed. He/She then put the resident's top and shoes on and pivot-transferred him/her to the wheelchair. The CNA wore the same pair of gloves the whole time. 3. Review of Resident #6's quarterly MDS, dated [DATE], showed:-Cognitively intact;-No behaviors;-Dependent on toileting hygiene;-Always incontinent of bowel and bladder;-Diagnoses included hemiplegia and depression. Review of the care plan, in use during the time of the investigation, showed:-Focus: The resident has an ADL deficit related to hemiplegia following a stroke affecting left non-dominant side:--Goal: The resident will maintain current level of function with ADLs through the review date;--Interventions: Does not use bed pan, toilet or commode. Utilize check and change to manage incontinency;-Focus: EBP:--Goal: To reduce the opportunities for transfer of MDROs during high contact resident care activities when contact precautions do not otherwise apply;--Interventions: EBP precautions. During an interview on 9/25/25 at approximately 9:36 A.M., the resident said he/she relied on staff for everything, including toileting. Sometimes he/she was left wet after pressing the call light for assistance. It happens more during evening and night shifts. During an observation and interview on 9/26/25 at 5:30 A.M., the resident lay in bed on his/her back. The resident said he/she pressed the call light and no one answered. He/she said he/she was soiled. An odor of urine was present in the resident's room. At 5:39 A.M., CNA I responded to the resident's call light. Observation on 9/26/25 at 5:40 A.M., showed CNA I entered the resident's room with some washcloths and an incontinent brief. He/She soaked the washcloths under running water 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	sink, then applied gloves, no gown was worn. CNA I lowered the resident's head of bed. He/She wrung the washcloths and placed them on the resident's foot of bed. He/She applied gloves, unfastened the brief, then rolled and pushed the brief under the resident. Without changing gloves or performing hand hygiene, he/she wiped the resident's groin area with one washcloth, twice on each groin, alternating left and right and using the same side of the washcloth. He/She did not wipe the genital area. He/She then rolled the resident to one side and wiped his/her buttocks with two swipes using one washcloth, then used another washcloth wiping the same area. The CNA did not wipe or clean the anal area. He/She then applied a clean brief, grabbed the sheet and blanket, and covered the resident while wearing the same gloves. He/She picked up the dirty washcloths, placed them in a bag and adjusted the resident's head of bed. He/She boosted the resident up in bed by pulling the incontinent pad. He/She then removed the gloves and left the room without performing hand hygiene. 4. Review of Resident #117's MDS, dated [DATE], showed:-Moderately impaired cognition;-Dependent on toilet hygiene, lower body dressing and chair/bed to chair transfer; -Partial/moderate assistance for upper body dressing;-Number of stage 3 pressure wounds (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed): one;-Diagnoses included: atrial fibrillation (a-fib, irregular heart rhythm), dementia, chronic kidney disease (CKD, impaired kidney function), pressure ulcer of unspecified heel, stage 3. Review of the resident's care plan, in use at the time of survey, showed:-Focus: ADL self-care performance deficit related to dementia:--Goal: resident requires assistance with ADL care and mobility; --Interventions included: Bed mobility: requires staff assistance to turn and reposition in bed; Dressing: requires staff assistance to dress; Personal hygiene-needed one assist;-Focus: EBP: wounds:--Goal: to reduce the opportunities for transfer of MRDO during high - contact resident care activities, when contact precautions do not otherwise apply;--Interventions: incorporate periodic monitoring/evaluation of adherence to infection prevention practices to determine the need for additional training/education. Review of the resident's order summary report, dated 9/25/25, showed a physician order for EBP (wounds) examples of high-contact resident care activities requiring gown and glove use for EBP. EBP Precautions: dressing, transferring, providing hygiene, changing briefs or toileting, and wound care: skin opening requiring a dressing. every shift. Observation on 9/26/25 at 5:40 A.M., showed a red EBP magnet on the door frame. The magnet did not show the type of PPE required or what type of high contact care activities required the use of gown and gloves. CNA E entered the resident's room, performed hand hygiene and put gloves on. Staff did not wear a gown. Then he/she pulled the covers back, unfastened the resident's brief and provided incontinence care and placed a new brief on the resident. While wearing the same gloves, CNA E went to the closet and removed a shirt and a pair of pants and dressed the resident. CNA E removed his/her gloves and left the room to get a gait belt. No hand hygiene was performed after removing his/her gloves. When CNA E returned to the room, he/she put gloves on, without performing hand hygiene, placed the gait belt around the resident ‘s waist and transferred the resident from the bed to the chair. Observation on 9/26/25 at 10:32 A.M., showed the resident sat in his/her wheelchair in his/her room. The Wound Practitioner and the wound nurse entered the resident's room, performed hand hygiene, and put gloves on. Staff did not wear a gown. The Wound Practitioner removed the dressings on the right heel and left foot. The Wound Practitioner said both wounds were 100% eschar (dead tissue). The Wound Practitioner instructed the wound nurse to paint the wounds with betadine and leave open to air (OTA). The wound nurse provided the treatment. 5. Review of Resident #69's quarterly MDS dated [DATE], showed:-Severe cognitive impairment;-Dependent on toilet hygiene, lower body dressing, rolling left to right and for chair/bed to chair transfers;-Partial/moderate assistance for upper body (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing;-Always incontinent of bowel and bladder;-Diagnoses included: heart failure, high blood pressure, renal insufficiency (partial kidney function failure characterized by less than normal urine excretion), diabetes, and Alzheimer's disease. Review of the resident's care plan, in use at the time of survey, showed:-Focus: ADL self-care performance deficit related to Alzheimer's disease and limited mobility:--Goal: will maintain current level of function with ADLs;--Interventions included: Toilet use: does not use bed pan, toilet or commode. Check and change to manage incontinency; Dressing: dependent on staff; Transfer: two person assist and mechanical lift;-Focus: EBP related to wounds:--Goal: to reduce the opportunities for transfer of MDRO during high contact resident care activities, when contact precautions do not otherwise apply;--Intervention included: Ensure access to alcohol-based hand rub; Examples of high-contact resident care activities requiring gown and glove use for all EBP precautions; transferring, providing hygiene, changing briefs; dressing, and wound care: skin opening requiring a dressing; Post signage on the door/wall outside of the resident's room; indicating the type of precautions & required PPE (e.g., gown and gloves). EBP signage should include high contact resident care activities that require the use of gown and gloves. Review of the resident's order summary report dated 9/30/25, showed a physician order for EBP (wounds) examples of high-contact resident care activities requiring gown and glove use for EBP. EBP Precautions: dressing, transferring, providing hygiene, changing briefs or toileting, and wound care: skin opening requiring a dressing. Every shift. Observation on 9/26/25 at 6:42 A.M., showed CNA E went to the linen cart in the hallway, gathered supplies, put his/her gloves on while in the hall, and entered the resident's room. There was a red EBP magnet on the door frame. The magnet did not show the type of PPE required or what type of high contact care activities required the use of gown and gloves. The resident lay in bed. CNA E pulled the covers back, unfastened the residents brief, provided incontinence care, rolled the resident towards the wall, provided incontinence care, removed the soiled brief and tucked a new brief halfway under the resident, rolled the resident towards the door, then onto his/her back, and adjusted and fastened the brief. He/She did not change gloves or perform hand hygiene during care. With the same gloves on, he/she went to the closet and removed a shirt and pair of pants. Then he/she rolled the resident side to side to put his/her pants on and placed the mechanical lift sling under the resident. CNA E removed his/her gloves and left the room without performing hand hygiene. A few minutes later CNA E returned with the Activities Director and the mechanical lift. Both staff performed hand hygiene and put gloves on, attached the lift sling to the lift and transferred the resident into his/her chair. The Activity Director unfastened the lift cloth from the lift, removed her gloves and performed hand hygiene, then removed the lift from the room. CNA E removed the resident's gown, put his/her shirt and heel protector boots on, removed his/her gloves and performed hand hygiene. Neither staff wore a gown while providing high contact, direct care. Observation on 9/26/25 at 12:25 P.M., showed the resident in bed. The Wound Practitioner and the wound nurse entered the resident's room, performed hand hygiene and put gloves on. Neither put a gown on. The resident was rolled towards the wall. The Wound Practitioner said the wound had a scant amount (small amount) of sero-sanguineous (clear and watery fluid seeping from a wound) drainage, the wound was a mixture of moisture associated skin damage (MASD, skin inflammation, erosion, or damage caused by prolonged exposure to moisture) and a pressure ulcer (injury to the skin and/or underlying tissue, as a result of pressure or friction). She instructed the wound nurse to apply triad (hydrophilic paste for light-to-moderate levels of wound exudate) cream and leave OTA. The wound nurse provided wound care. 6. Review of Resident #75's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included: heart failure, high blood pressure, renal insufficiency, diabetes and depression. Review of the (continued on next page)

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	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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's order summary, dated 9/25/25, showed a physician order for EBP (wounds) examples of high-contact resident care activities requiring gown and glove use for EBP. EBP Precautions: dressing, transferring, providing hygiene, changing briefs or toileting, and wound care: skin opening requiring a dressing. Every shift. Observation and interview on 9/25/25 at 10:33 A.M., showed a red EBP magnet on his/her door frame. The magnet did not show the type of PPE required or what type of high contact care activities required the use of gown and gloves. The resident said water gets under his/her skin then it weeps. The resident pulled up his/her pant leg, there was a small amount of yellowish drainage weeping from the right mid-shin area. There was no dressing over the wound. Observation on 9/26/25 at 12:29 P.M., showed the wound nurse entered the resident's room, and put gloves on, he did not put a gown on. The wound nurse said the wound was 2.3 centimeter (cm) X 3.5 cm X 0 and it had a small amount of weeping. He cleaned the wound with wound cleanser, applied triad cream and a dry dressing. 7. Review of Resident #57's quarterly MDS, dated [DATE], showed:-Serve cognitive impairment;-Diagnoses included: heart failure, high blood pressure, anxiety and non-Alzheimer's dementia;-Number of stage 3 pressure ulcers: one. Review of the resident's care plan in use at the time of survey, showed:-Focus: EBP: wounds;-Goal: to reduce the opportunities for transfer of MDRO during high - contact resident care activities, when contact precautions do not otherwise apply;-Interventions: incorporate periodic monitoring/evaluation of adherence to infection prevention practices to determine the need for additional training/education. Review of the order summary report, dated 9/25/25, showed a physician order for EBP (wounds) examples of high-contact resident care activities requiring gown and glove use for EBP. EBP Precautions: dressing, transferring, providing hygiene, changing briefs or toileting, and wound care: skin opening requiring a dressing. Every shift. Observation on 9/26/25 at 12:15 P.M., showed the resident lay in bed. There was an EBP magnet on the door frame. The Wound Practitioner and wound nurse entered the room, performed hand hygiene, and put gloves on. Neither wore a gown. The Wound Practitioner removed the dressing on the resident's buttocks area. The Wound Practitioner described the wound as a stage 2 pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, may also present as an intact or open/ruptured blister). The Wound Practitioner instructed the wound nurse to use triad cream and leave OTA. The wound nurse provided wound care. 9. During an interview on 9/30/25 at 8:40 A.M., CNA U said hand hygiene should be done when you enter the room, after you set up your supplies, between dirty and clean and after you finish providing care. Residents should be wiped from front to back and the washcloth turned after each wipe. If there was a red EBP magnet on the door frame that meant one person in the room was on oxygen. Currently there are no residents on the hall that required EBP. 10. During an interview on 9/30/25 at 9:00 A.M., Certified Medication Technician (CMT) T said when he/she provided incontinence care, he/she performed hand hygiene and put on/changed gloves when he/she entered the room, changed the water and after the task was completed. Residents should be wiped from front to back. If a resident was on EBP that meant staff should keep their hands washed and wear gloves while providing care to the resident. He/She knew which residents were on EBP because the nurse/nurse manager would tell them. Also, it would be on the Kardex (gives a brief overview of each resident). CMT T identified one resident who was on EBP. When asked about the red EBP magnet on the door frame of another resident, CMT T said, I'm confused, I will have to ask some questions. 11. During an interview on 9/30/25 at 9:30 A.M., CMT S said he/she performed hand hygiene and put on/changed gloves before and after providing care. When providing incontinence care, residents should be wiped from front to back. He/She knew which residents required EBP by the sign on the door. If a resident was on EBP, staff should wear mask, gown and gloves every time they go into the resident's room. 12. During an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 9/30/25 at 7:48 A.M., Licensed practical Nurse (LPN) O said staff provide universal precautions for all residents. If more precautions are required, a sign on the door will identify what type of precautions are required. For example, contact precautions would have a sign indicating the type of PPE required with the PPE kit set up outside the room. For EBP, there is a sign outside the door, and a PPE kit set up in the room. Staff were in-serviced on EBP and what PPE is required for these residents. If a resident is on EBP, staff are to wear gloves and gown when providing any hands-on care. Regarding incontinence care, staff were provided with in-service training a couple weeks ago. Staff had a skills day. Direct care staff were required to demonstrate providing care and they were quizzed. Any issues identified were corrected at that time. 13. During an interview on 9/30/25 at 8:40 A.M. Registered Nurse (RN) B said residents who have wounds required EBP. Staff should wear gown and gloves every time they go into the resident's room. Staff know which residents required EBP because by the signage on the door, or they can look in the computer and a red flag will pop up. 14. During an interview on 9/30/25 at 11:23 A.M., the Wound Nurse said if a resident was on EBP staff should wear gloves, gown, and perform hand hygiene when providing high contact care and when providing wound care. EBP should be used when the wound is open or weeping. If the wound was not open, there was no need for EBP. He knew which residents required EBP by the red magnet on the door, signs on the door and it pops up on the nurse Medication Administration record (MAR). He checked the chart and confirmed Residents #69, #57, #117 and #75 were on EBP. 15. During an interview on 9/30/25, the Assistant Director of Nursing (ADON) said she was also responsible for infection control. Staff should perform hand hygiene when they enter the room, after care is provided and/or before they leave the room. When staff provide peri care she would expect for staff to explain what they are going to do, perform hand hygiene, gather their supplies, perform hand hygiene, wipe the resident from front to back, and fold the towel after each wipe, perform hand hygiene and roll the resident to wash the back, cleaning front to back and turning the towel after each wipe. Once completed, staff should perform hand hygiene. Staff have recently been in-serviced on incontinent care. Residents who have wounds require EBP. Staff should wear gown and gloves and a face shield if needed while providing high contact care and wound care. Staff know which residents required EBP by the red magnet on the doorframe, the physician orders, care plan and recent in-services. She would expect for staff and all providers to use EBP during high contact care and when performing wound care. 16. During an interview on 9/30/25 at 12:24 P.M., the Director of Nursing (DON) said when providing incontinence care, gloves should be changed and hands sanitized after touching a soiled surface and before touching a clean surface. Hand hygiene should be performed with glove changes. Staff should not double glove in place of glove changes and hand hygiene. If a gloved hand is used to apply ointment to the buttocks, the same gloved hand should not be used to touch the resident, their pillow or other clean surfaces. When providing care, all areas potentially soiled should be cleaned, to include the genitals. Staff know which residents are on EBP by signs on the doors. Staff should wear PPE, gowns, gloves and shield if needed. Staff only need to wear PPE when providing care. 17. During an interview on 9/30/26 at 12:20 P.M., the Administrator said she would expect for staff to follow physician orders and the facility's policy and procedures.

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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. 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 (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 working on it. The pest control company comes, and staff clean daily. During an observation and interview on 9/29/25 at 9:19 A.M., the Dietary Manager (DM) said regarding pests, she had not seen any roaches. Food debris should not be left overnight. Staff should clean before they leave. Closing duties include clean up all the food debris before leaving for the day. The surveyor showed the DM a dead roach that lay on the bottom shelf of the steamtable. The DM said it should have been cleaned up. During an interview with the Administrator, Director of Nursing, and Corporate Administrator on 10/1/25 at 12:19 P.M., the Administrator said when the pest control company comes, they do not leave any recommendations of things to do to decrease the chance of getting pests with her. If they left recommendations, it would be with the maintenance supervisor. Part of an effective pest control program includes cleaning the kitchen of food debris and trash. 257375925821422584514