STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265668	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the Department of Health and Senior Services (DHSS) within the required timeline after two residents reported a staff member verbally abused them (Resident #1 and Resident #2). Staff also failed to report the abuse to facility administration in a timely manner. The sample size was four. The census was 80. Review of the facility's Abuse and Neglect policy dated 7/25/24, showed: -Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames; -Definitions: -Verbal abuse: Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. This includes profanity or speaking in a demeaning, non therapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident, mocking, insulting, ridiculing, yelling at a resident with the intent to intimidate, threatening residents including but not limited to, depriving a resident of care or withholding a resident from contact with family and friends and isolating a resident from social interaction or activities; -Mental abuse: -Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation or abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident. Mental abuse includes the use of verbal or nonverbal conduct with causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. This includes hovering over a resident with the intent to intimidate, threatening residents including but not limited to, depriving a resident of care or withholding a resident from contact with family and friends and isolating a resident from social interaction or activities; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Policy: -Guidelines: -The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences; -Prevention: The facility will provide resident, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution and will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur; -Alleged violation: A situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect or abuse, including injuries of unknown source and misappropriation of resident property; -Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response as described below; -Protection: The facility will protect residents from harm during an investigation; -Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences; -Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: Any owner, operator, employee, manager, agent or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline without fear of retaliation; -When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: -The Licensed Nurse will: -Respond to the needs of the resident and protect him/her from further incident; -The facility shall immediately call 911 when there is a medical emergency. All other notifications should be made (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	using a non-emergency number; -Remove the accused employee from resident care areas; -Notify the Administrator or designee; -Notify the attending physician, resident's family/legal representative and medical director; -Monitor and document the resident's condition, including response to medical treatment or nursing interventions; -Document actions taken in the medical record; -Complete an incident report if indicated; -The Administrator or designee will: -Should the incident be a reportable event, notify the appropriate agencies immediately, as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than two hours after discovery or forming the suspicion. Should the event not be reportable, continue and complete the investigation with all supporting information and place in file with all investigation; -Within five working days of the incident, report sufficient information to describe the results of the investigation and indicate any corrective actions taken, if the allegation was verified; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notifications: The facility must ensure that all alleged violations involving abuse, neglect, exploitation, mistreatment or sexual assault including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency. If the abuse involves alleged suspicion of crime, it must also be reported to local law enforcement within those time frames. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/23/24, showed: -Adequate hearing/vision; -Ability to express ideas and wants; -Ability to understand others: Understands others; -Mobility device: Cane; -No behaviors or refusal of care listed; -Diagnoses of major depressive disorders, bipolar disorder (a mental illness that causes extreme mood swings, or shifts in energy, thinking, behavior, and sleep) and high blood pressure. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 11:00 A.M., Resident #1 said he/she likes to look out for the other residents and used to be the resident council president. On 10/19/24, he/she went outside to smoke after lunch. He/She did not know what time it was exactly because he/she was used to years of going outside whenever he/she wanted to go smoke. It was a force of habit. He/She smoked on the side of the building away from the main courtyard. There were three other residents out there with him/her that morning. He/She was seated by a tree smoking and listening to something on his/her headphones. He/She was not paying much attention to anyone until he/she heard someone loudly demand, What's your name? He/She looked up and saw Certified Nursing Assistant (CNA) G standing in front of Resident #2 with his/her fist balled up and body in an aggressive stance. Resident #2 told the staff member F-ck you. He/She told the staff member to tell his/her story walking. Due to the aggressive way the staff member was approaching the resident, Resident #1 took off his/her headphones and stood up and asked the staff member his/her name since he/she was not wearing a name badge and the resident wanted to report his/her behavior to administration. The staff member said, F*ck you and squared off toward him/her too. The resident felt threatened because the staff member was very large and appeared to be very angry. He/She did not feel safe at that point. The resident told the staff member he/she was going to report him/her. The staff member told the resident he/she was not afraid of him/her and would beat his/her ass too. The resident was not sure what else was said because everyone was yelling at everyone. Then the maintenance staff member came out of the door and told the staff member to go inside. Resident #1 was still very angry and wanted to report the incident. The maintenance staff member walked with him/her, but they took the stairs because the other staff member was standing by the elevator and the maintenance staff member did not want him/her to be in the same elevator with the staff member. They went up to the third floor and met with Licensed Practical Nurse (LPN) H. Resident #3 came up to the desk at that time and was telling the nurse the same story. LPN H told them he/she was not in charge so Resident #1, the Maintenance Director and LPN H all went up to talk to Registered Nurse (RN) E. Resident #1 told RN E what happened, and the nurse asked him/her to write a statement. He/She went to his/her room and wrote out a long statement about what happened and gave it to RN E. Resident #1 did not see the CNA again that day, but he/she was upset when he/she saw the CNA in the dining room the next evening. The resident complained to the nurse on duty about the staff member being back in the building. He/She told the nurse if they did not do something about the CNA by 10/22/24, he/she was going to report them. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Adequate hearing/vision; -Ability to express ideas and wants; -Ability to understand others: Understands others; -No behaviors or refusal of care listed. -Diagnoses of stroke, major depressive disorder, high blood pressure and anxiety. Review of the resident's care plan dated 10/14/24, showed: -Discipline; -Problem: Potential for decline in activity participation; (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Resident follow his/her own agenda. He/She continues to join smoking group. He/She interacts appropriately with peers and staff; -Problem: Potential for change in mood/behavior; -Interventions: Behavior is usually appropriate and cooperative with care. Distract from behavior with alternate activity. Redirect as needed/usually easily redirected by staff. Allow venting of fears/frustrations. Give reassurance if needed. During an interview on 10/21/24 at 11:45 A.M., the resident said he/she and three other residents were outside smoking on 10/19/24 when CNA G climbed out of the window. The staff member demanded their names and told them to put out their cigarettes because it was not time to smoke. The resident told the staff member they were not bothering anybody and he/she could not demand they stop smoking. The staff member told the resident he/she could demand this and turned to walk away. The resident told him/her to Tell your story walking and he/she turned around and told him/her You don't have to get smart. Then the staff member got in a stance like he/she was going to hit somebody and started yelling. CNA G threatened to knock his/her Old ass out. Then Resident #1 stood up and the staff member asked him/her if he/she was planning to hit him/her with his/her cane. The staff member said I will take that cane and whip all your asses. Then one of the residents said F*ck it. He/She is going to jump us. There are four of us and only one of him. The resident felt threatened because the staff member was very large and was acting crazy. They were all yelling at each other and then the maintenance staff member came out and sent the staff member back inside. He/She did not see the staff member the rest of the day but he/she was back in the dining room the next day. He/She did not write a statement because no one believes them anyway. Review of Resident #4's quarterly MDS, dated [DATE], showed: -Adequate hearing/vision; -Ability to express ideas and wants; -Ability to understand others: Understands others; -No behaviors or refusal of care listed. -Diagnoses of stroke, major depressive disorder, high blood pressure and anxiety. Review of the resident's care plan dated 10/9/24, showed: -Discipline; -Problem: Potential for decline in activity participation; -Interventions: Resident follows his/her own agenda. He/She continues to join smoking group; -Problem: Potential for change in mood/behavior; (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Usually friendly and socializes with others. Cooperative with care. Distract from behavior with alternate activity. Redirect as needed/usually easily redirected by staff. Allow venting of fears/frustrations. Give reassurance if needed. Review of the resident's written statement dated 10/19/24, showed he/she was asked his/her name and he/she answered, and the staff member introduced him/herself as honey and then asked him/her to put out the smoke and he/she did so. During an interview on 10/21/24 at 12:30 P.M., Resident #4 said he/she was sitting on a window ledge outside in the smoking area when CNA G came up behind him/her from inside the building and asked him/her to move. The CNA then climbed out of the window and approached the three other residents and told them to put their cigarettes out. The residents got angry and started yelling and badgering him/her. The CNA said, Don't be like that. The staff member did step back to square off but it was more of a defensive manner. He/She was more threatened by the residents coming towards him/her. He/She told them not to come forward. He/She did say You aren't going to do shit. The Housekeeper told him/her to step away. It could have went either way. He/She had never seen the residents act that way before. Observation on 10/21/24 during the on-site visit from 9:30 A.M. to 4:30 P.M., showed Resident #3 was unavailable for interview. During interviews on 10/21/24 at 10:30 A.M. and at 3:00 P.M, the Maintenance Director said on 10/19/24, he was working on the third floor and looked out the window and saw a staff member in a commotion. There were several residents and CNA G were going back and forth with each other. The Maintenance Director immediately ran down the stairs to the first floor. When he arrived downstairs to the first floor courtyard where the residents and CNA were located, the four residents appeared to be advancing towards the CNA and he/she was backing up against the building. The residents and the staff member were all yelling at each other. It was hard to understand what was being said because it was so loud. The Maintenance Director quickly stepped between them to deescalate the situation. He told the staff member to go back into the building while he/she tried to calm the residents down. The staff member appeared to be very agitated. The residents were very upset and threatening to damage the staff member's car. The Maintenance Director talked to them and told them not to overreact and they would investigate the situation. Resident #1 was very angry and said he/she was going into the building to report the incident to the supervisor. The Maintenance Director walked in with the resident because he/she was so agitated and he/she did not want the resident and staff member to get into another altercation. They went up the stairs and spoke to LPN H to find out who was in charge. Then they went up to RN E, and the Maintenance Director left the resident with the nurse to report his/her concerns. The Maintenance Director then talked to the CNA. The CNA told him, he/she took responsibility for his/her actions. He/She had told the residents You are not going to beat nothing. I will beat your ass. CNA G admitted using profanity and when Resident #1 stood up he/she said, What are you going to do? I will beat your ass too. He did not write this in his statement because he did not actually witness it. He knew all allegations of abuse had to be reported but thought the Director of Nurses (DON) had reported it. Review of CNA F's written statement dated 10/19/24, showed around 12:45 P.M. to 1:00 P.M., some residents were outside smoking. LPN H overheard the conversation through the window and sent help. CNA G went to get another resident and saw the residents smoking outside of their smoking times and told the residents not to smoke. Then they got mad and things started to lose control. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 12:40 P.M., CNA F said on 10/19/24, he/she went outside to try and get another resident who would not come in. He/She told Nurse H who asked CNA G to go down and get the resident. CNA F told CNA G there were some residents in the courtyard smoking. CNA G went out and got the resident CNA F was asking for and brought him/her into the building. CNA F did not see what happened after that because he/she was trying to get the other resident on the elevator. Then he/she saw the Maintenance Director running down the stairs. CNA F told the resident to hold on and went outside. When he/she got outside, the residents and CNA G were all arguing back and forth, and the Maintenance Director was trying to break it up. It was very heated. Everyone looked upset. Then CNA G came back into the building. CNA F did not report it because he/she thought the nurse reported it. Review of a written statement by LPN H dated 10/19/21, showed he/she was standing in the hallway by the third floor elevators. The Maintenance Director was speaking to three residents about an argument that happened in the smoking area with CNA G. During an interview on 10/21/24 at 2:55 P.M., LPN H said he/she did not see the incident, but he/she heard hollering and then saw the Maintenance Director run downstairs. Then he/she saw them come upstairs, and the Maintenance Director was asking them questions. LPN H heard the residents telling the Maintenance Director about CNA G threatening to hit them with a cane. Resident #1 told the nurse he/she was mad the next day when he/she saw the CNA back at work because the staff member had threatened the residents the day before. LPN H knew all allegations of abuse needed to be reported but did not report it to anyone because he/she thought the Maintenance Director dealt with it and reported it. During an interview on 10/21/24 at 2:15 P.M., RN E said Resident #1 told him/her he/she had an argument with CNA G because he/she was not supposed to be smoking. The resident said the CNA was disrespectful. The RN called the DON who said staff were not supposed to get in arguments with residents and told him/her to get statements. The resident wrote out a statement, but RN E could not make sense of it. The resident did not elaborate on what the CNA did that was disrespectful, and RN E did not ask. He/She just thought the resident was mad because he/she could not smoke. The CNA was shook up because he/she thought the resident was going to hit him/her with his/her cane. RN E sent CNA G home for the day. He/She was allowed to come back the next day, but the nurse talked to him/her about watching what he/she said and no verbal abuse. He/She did report the allegations because he/she gave the information to administration, who is responsible to investigate, and they did not tell him/her to call anyone and report it. He/She thought the allegations had been reported by administration. Review of a written statement by the Social Worker on 10/19/24, showed he/she was in the building attempting to complete social service obligations and did not hear or witness any interactions with any residents or staff members. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 10:00 A.M., the Social Worker said 10/19/24 was his/her off day, but he/she came in to make up some hours. The nurse from the fourth floor (RN E) asked him/her to gather statements from the residents because they were upset about an incident that happened in the smoking area. He/She interviewed Resident #2 who said he/she might be in trouble because he/she told staff there were four of them and only one of him/her. The resident hated the new smoking policy because they used to be able to go out whenever they wanted. Resident #2 also told the staff member I'm grown. Say that shit while you are walking. Resident #4 did not want to say what happened. He/She was just frustrated about being told what to do when they were adults. Resident #1 said the staff member got upset because he/she asked them to do something and they did not feel like he/she had a right to ask them to do it. The Social Worker assumed the staff member had left it alone. He/She did not ask the residents if the staff member cursed or threatened them. He/She knew they were upset but thought it was about not being able to smoke. The Social Worker knew he/she was supposed to report verbal abuse but none of the residents said they were verbally abused, so he/she did not think he/she had to report the incident. During an interview on 10/21/24 at 3:45 P.M., CNA G said a CNA stopped him/her and said residents were out in the smoking area and asked if he/she could ask them to come in. The residents were standing on the side of the building. The CNA knocked on the window and asked their names and if they were familiar with the smoke policy. One of the residents said, This is my f*cking house. I can do what I want. The CNA came out and told them they are not supposed to be smoking and they kept cussing him/her out. They said We will jump your ass. Resident #2 started walking up on him/her. There was another staff member outside, but he/she did not help at all. CNA G told the residents You are not going to beat my ass and started to yell for help. He/She did not threaten them. The Maintenance Director came down and helped. CNA G did not even know these residents. He/She was not going to fight them. He/She thought they were intimidated by his/her size. He/She was allowed to come back the next day. No one in-serviced him/her on abuse/neglect after he/she came back. They just told him/her to stay on the fourth floor and away from the residents. Review of the investigation sent by the facility dated 10/25/24, showed: -During the complaint survey on 10/21/24, the surveyor notified the Administrator that Resident #1 alleged verbal abuse from staff, and that he/she provided a statement to the Charge Nurse. The verbal abuse was alleged to have taken place on 10/19/24; -The resident alleged he/she intervened in an incident between CNA (G) and Residents #2, #3 and #4 in which those residents were asked to smoke at the scheduled times; -The resident alleged the CNA said to him/her, I will f*ck you up; -The initial report and statements provided to the Administrator on 10/19/24 were the residents were upset with the CNA due to his/her attempt to enforce the smoking policy; -The DON asked the CNA to leave the facility until statements were gathered related to the incident; -Statements from staff claimed they did not have knowledge of any interactions between the parties; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At no time on 10/19/24, was the Administrator made aware of an allegation of verbal abuse; -Per the surveyor on 10/21/24, RN E was interviewed and stated Resident #1 was upset and provided a written statement related to the incident; -The nurse stated the resident did not allege verbal abuse from staff, and he/she did not read the statement; -The alleged statement was not received by the Administrator or DON; -Upon notification of the allegation, the DON obtained a statement from the resident and notified his/her physician; -The surveyor also interviewed the Maintenance Director on 10/21/24 who stated the CNA admitted to him that he/she used inappropriate language towards the resident, however the statement he/she provided in writing did not indicate this; -Other residents who were present at the time of the alleged abuse were interviewed. Resident #4 stated the CNA asked the residents for their names and asked they follow the smoking policy; -Resident #2 stated Nothing happened and refused to provide a written statement; -Resident #3 also declined to provide a statement; -Occurrence Resolution: Based on the evidence obtained as a result of the investigation, it is inconclusive as to whether or not verbal abuse occurred; -The CNA is no longer an employee. During an interview on 10/21/24 at 1:00 P.M., the DON said RN E called her on 10/19/24 around 1:00 P.M., and said a verbal altercation had occurred between the residents and staff, but he/she did not know what happened or who was involved. She then talked to the Maintenance Director who told her he overheard loud voices and came downstairs to see the residents advancing on the staff member. The DON had them get statements and told them to send the staff member home. It was her understanding the residents got aggressive with the staff member who originally told them it was not their smoke break time and went outside anyway. When CNA G approached them about it Resident #2 told him/her It is four against one and we will beat the f*ck out of you. The residents did not report the staff member cursed or threatened them. None of the staff reported the staff member cursed or threatened the residents. She felt like the investigation was over at this point and notified the Administrator of this. She allowed the CNA to come back the next day to work his/her shift but told him/her to stay on the fourth floor and have nothing to do with the residents. She did not report the incident because she did not know about the allegations. (continued on next page)

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	265668	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 3:50 P.M., the Administrator said the DON called and told her four residents were cursing at an aide and threatened to hit him with a cane. No one said anything about him/her cursing back. Cursing at or threatening residents would be considered verbal abuse. She thought the argument was about smoking times. The employee was sent home because the residents were so upset. If she had known an allegation of verbal abuse occurred, she would have reported it immediately and involved law enforcement. MO00243836

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on interview and record review, the facility failed to ensure they followed their abuse and neglect policy by failing to conduct a thorough investigation into one resident's (Resident #1) allegation a Certified Nursing Assistant (CNA) cursed and threatened him/her on 10/19/24. The resident reported the allegation on 10/19/24 and on 10/20/24 when he/she saw the CNA back at the facility. The facility initiated an investigation on 10/19/24, but failed to thoroughly interview all staff involved, interview other residents, document verbal statements and make appropriate notifications. The census was 80. Review of the facility's Abuse and Neglect policy dated 7/25/24, showed: -Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames; -Definitions: -Verbal abuse: Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. This includes profanity or speaking in a demeaning, non therapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident, mocking, insulting, ridiculing, yelling at a resident with the intent to intimidate, threatening residents including but not limited to, depriving a resident of care or withholding a resident from contact with family and friends and isolating a resident from social interaction or activities; -Mental abuse: -Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation or abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident. Mental abuse includes the use of verbal or nonverbal conduct with causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. This includes hovering over a resident with the intent to intimidate, threatening residents including but not limited to, depriving a resident of care or withholding a resident from contact with family and friends and isolating a resident from social interaction or activities; -Policy: -Guidelines: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences; -Prevention: The facility will provide resident, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution and will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur; -Alleged violation: A situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect or abuse, including injuries of unknown source and misappropriation of resident property; -Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response as described below; -Protection: The facility will protect residents from harm during an investigation; -When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: -The Licensed Nurse will: -Respond to the needs of the resident and protect him/her from further incident; -The facility shall immediately call 911 when there is a medical emergency. All other notifications should be made using a non-emergency number; -Remove the accused employee from resident care areas; -Notify the Administrator or designee; -Notify the attending physician, resident's family/legal representative and medical director; -Monitor and document the resident's condition, including (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	response to medical treatment or nursing interventions; -Document actions taken in the medical record; -Complete an incident report if indicated; -The Administrator or designee will: -Complete an administrative investigation to include personal statements from staff involved in a situation that has any type of accusations of abuse either staff or resident abuse, any unexpected medical emergency or when the administrative staff feel uncomfortable in any situation involving resident care or treatment or staff treatment; -Suspend the accused employee pending completion of the investigation; -Should the incident be a reportable event, notify the appropriate agencies immediately, as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. Should the event not be reportable, continue and complete the investigation with all supporting information and place in file with all investigation; -The administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including the facts that prove or disprove the alleged situation occurred, the plan of corrective action by the administrative staff, all statements attached from residents and staff involved and any training or education that the administration feels needs to be provided to staff or residents to ensure education has been provided to prevent future similar situations; -The administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician was made aware, the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated and the plan of care was updated to reflect the change in medical or behavioral status; -Within five working days of the incident, report sufficient information to describe the results of the investigation and indicate any corrective actions taken, if the allegation was verified; -Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway; -Employees of the facility who have been accused of mistreatment will be immediately removed from contact with any residents and must leave the facility pending the results of the investigation and review by the administrator; -Employees accused of possible mistreatment shall not complete the shift and will immediately be sent home. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/23/23, showed: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Adequate hearing/vision; -Ability to express ideas and wants; -Ability to understand others: Understands others; -Mobility device: Cane; -No behaviors or refusal of care listed. -Diagnoses of major depressive disorders, bipolar disorder (a mental illness that causes extreme mood swings, or shifts in energy, thinking, behavior, and sleep) and high blood pressure. Review of the resident's undated trauma screening questionnaire, showed he/she responded yes to heightened awareness of potential dangers to yourself and others. Review of Resident #1's written statement dated 10/21/24, showed: -On 10/19/21, after lunch, he/she and four other residents were on the south side of the solarium. A member of the staff approached aggressively and went after Resident #2 demanding his/her name. Resident #2 responded F*ck you. The staff member went into a fighting stance and stated, Bring it on. Staff was using the F word and the resident was using the F word as well; -Resident #1 got up and asked the staff member his/her name, and the staff member squared off against the resident. The staff member started to walk away and Resident #3 said There are four of us and Resident #1 told him/her to Shut up; -Resident #1 asked the staff member his/her name again and he/she walked away; -The resident came in the building behind staff and the maintenance staff person stopped him/her; -The resident told the maintenance staff person he/she was going to report this to whoever was in charge. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/24 at 11:00 A.M., Resident #1 said he/she likes to look out for the other residents and used to be the resident council president. On 10/19/24, he/she went outside to smoke after lunch. He/She did not know what time it was exactly because he/she was used to years of going outside whenever he/she wanted to go smoke. It was a force of habit. He/She smoked on the side of the building away from the main courtyard. There were three other residents out there with him/her that morning. He/She was seated by a tree smoking and listening to something on his/her headphones. He/She was not paying much attention to anyone until he/she heard someone loudly demand, What's your name? He/She looked up and saw CNA G standing in front of Resident #2 with his/her fists balled up and body in an aggressive stance. Resident #2 told the staff member F-ck you. He/She told the staff member to Tell his/her story walking. Due to the aggressive way the staff member was approaching the resident, Resident #1 took off his/her headphones and stood up and asked the staff member his/her name since he/she was not wearing a name badge and the resident wanted to report his/her behavior to administration. The staff member said, F*ck you and squared off toward him/her too. The resident felt threatened because the staff member was very large and appeared to be very angry. He/She did not feel safe at that point. The resident told the staff member he/she was going to report him/her. The staff member told the resident he/she was not afraid of him/her and would beat his/her ass too. The resident was not sure what else was said because everyone was yelling at everyone. Then the maintenance staff person came out of the door and told the staff member to go inside. Resident #1 was still very angry and wanted to report the incident. The maintenance staff person walked with him/her, but they took the stairs because the other staff member was standing by the elevator and the maintenance staff person did not want him/her to be in the same elevator with the staff member. They went up to the third floor and met with Licensed Practical Nurse (LPN) H. Resident #3 came up to the desk at that time and was telling the nurse the same story. LPN H told them he/she was not in charge so Resident #1, the Maintenance Director and LPN H all went up to talk to Registered Nurse (RN) E. Resident #1 told RN E what happened and the nurse asked him/her to write a statement. He/She went to his/her room and wrote out a long statement about what happened and gave it to RN E. Resident #1 did not see the CNA again that day, but he/she was upset when he/she saw the CNA in the dining room the next evening. The resident complained to LPN H about the staff member being back in the building after he/she threatened to hit him/her with a cane the day before. Resident #1 told the nurse if they did not do something about the CNA by 10/22/24, he/she was going to report them. Review of Resident #2's quarterly MDS, dated [DATE], showed: -Adequate hearing/vision; -Ability to express ideas and wants; -Ability to understand others: Understands others; -No behaviors or refusal of care listed; -Diagnoses of stroke, major depressive disorder, high blood pressure and anxiety. Review of the resident's care plan dated 10/14/24, showed: -Discipline; -Problem: Potential for decline in activity participation; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Resident follows his/her own agenda. He/She continues to join smoking group. He/She interacts appropriately with peers and staff; -Problem: Potential for change in mood/behavior; -Interventions: Behavior is usually appropriate and cooperative with care. Distract from behavior with alternate activity. Redirect as needed/usually easily redirected by staff. Allow venting of fears/frustrations. Give reassurance if needed. Review of the resident's progress notes on 10/21/24, showed no documentation of incident on 10/19/24. During an interview on 10/21/24 at 11:45 A.M., the resident said he/she and three other residents were outside smoking on 10/19/24 when CNA G came out of the window. The staff member demanded their names and told them to put out their cigarettes because it was not time to smoke. The resident told the staff member they were not bothering anybody and he/she could not demand they stop smoking. The staff member told the resident he/she could demand this and turned to walk away. The resident told him/her to Go tell your story walking and the staff member turned back around and told him/her You don't' have to get smart. Then the staff member got in a stance like he/she was going to hit somebody and started to yell at them. CNA G threatened to knock his/her Old ass out. Then Resident #1 stood up and the staff member asked him/her if he/she was planning to hit him/her with his/her cane. The staff member said I will take that cane and whip all your asses. Then one of the residents said F*ck it. He/She is going to jump us. There are four of us and only one of him. The resident felt threatened because the staff member was very large and was acting crazy. They were all yelling at each other and then the maintenance staff member came out and sent the staff member back inside. Resident #2 did not see CNA G the rest of the day, but he/she was back in the dining room the next day. Resident #2 did not write a statement because no one believes them anyway. Review of Resident #4's quarterly MDS, dated [DATE], showed: -Adequate hearing/vision; -Ability to express ideas and wants; -Ability to understand others: Understands others; -No behaviors or refusal of care listed. -Diagnoses of stroke, major depressive disorder, high blood pressure and anxiety. Review of the resident's care plan dated 10/9/24, showed: -Discipline; -Problem: Potential for decline in activity participation; -Interventions: Resident follows his/her own agenda. He/She continues to join smoking group; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem: Potential for change in mood/behavior; -Interventions: Usually friendly and socializes with others. Cooperative with care. Distract from behavior with alternate activity. Redirect as needed/usually easily redirected by staff. Allow venting of fears/frustrations. Give reassurance if needed. Review of the resident's written statement dated 10/19/24, showed he/she was asked his/her name and he/she answered, and the staff member introduced him/herself as honey and then asked him/her to put out the smoke and he/she did so. During an interview on 10/21/24 at 12:30 P.M., Resident #4 said he/she was sitting on a window ledge outside when CNA G came up behind him/her from inside the building and asked him/her to move. The CNA then climbed out of the window and approached the three other residents and told them to put their cigarettes out. The residents got angry and started yelling and badgering him/her. The CNA said, Don't be like that. The staff member did step back to square off, but it was more of a defensive manner. He/She was more threatened by the residents coming towards him/her. CNA G told them not to come forward. CNA G did say You aren't going to do shit. The Housekeeper told him/her to step away. It could have went either way. Resident #4 had never seen the residents act that way before. Observation during the on-site visit on 10/21/24 from 9:30 A.M. to 4:30 P.M., showed Resident #3 was unavailable for interview. Review of the Maintenance Director's written statement dated 10/19/24, showed while inside the building he heard a commotion in the smoking area. He rushed down and tried to get control of the situation and calm everyone down. He got statements from all parties involved. He did not witness any verbally abusive language from the employee at that time. The four residents were using inappropriate language and being aggressive when he arrived. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 10/21/24 at 10:30 A.M. and at 3:00 P;M, the Maintenance Director said on 10/19/24, he was working on the third floor and looked out the window and saw a staff member in a commotion. There were several residents and CNA G were going back and forth with each other. The Maintenance Director immediately ran down the stairs to the first floor. When he arrived downstairs to the first floor courtyard where the residents and CNA were located, the four residents appeared to be advancing towards the CNA, and he/she backing up against the building. The residents and the staff member were all yelling at each other. It was hard to understand what was being said because it was so loud. The Maintenance Director quickly stepped between them to deescalate the situation. He told the staff member to go back into the building while he/she tried to calm the residents down. The staff member appeared to be very agitated. The residents were very upset and threatening to damage the staff member's car. The Maintenance Director talked to them and told them not to overreact and they would investigate the situation. Resident #1 was very angry and said he/she was going into the building to report the incident to the supervisor. The Maintenance Director walked in with the resident because he/she was so agitated, and he/she did not want the resident and staff member to get into another altercation. They went up the stairs and spoke to LPN H to find out who was in charge. Then they went up to RN E, and the Maintenance Director left the resident with the nurse to report his/her concerns. The Maintenance Director then talked to the CNA. The CNA told him, he/she took responsibility for his/her actions. He/She had told the residents You are not going to beat nothing. I will beat your ass. He/She admitted using profanity and when Resident #1 stood up he/she said, What are you going to do? I will beat your ass too. He did not write this in his statement because he did not actually witness it. Review of CNA F's written statement dated 10/19/24, showed around 12:45 P.M. to 1:00 P.M. some residents were outside smoking. LPN H overheard the conversation through the window and sent help. CNA G went to get another resident and saw the residents smoking outside of their smoking times and told the residents not to smoke. Then they got mad and things started to lose control. During an interview on 10/21/24 at 12:40 P.M., CNA F said he/she went outside to try and get another resident in who would not come in. Nurse H told CNA G to go down and get the resident. CNA F told CNA G there were some residents in the courtyard smoking and he/she went out there and got the resident he/she was asking for and brought him/her into the building. CNA F did not see what happened after that because he/she was trying to get the other resident on the elevator. Then he/she saw the Maintenance Director running down the stairs. CNA F told the resident to hold on and went outside. When he/she got outside the residents and CNA G were all arguing back and forth, and the Maintenance Director was trying to break it up. It was very heated. Everyone looked upset. Then CNA G came back into the building. He/She looked very frustrated. Review of a written statement by LPN H dated 10/19/21, showed he/she was standing in the hallway by the third floor elevators. The Maintenance Director was speaking to three residents about an argument that happened in the smoking area with CNA G. During an interview on 10/21/24 at 2:55 P.M., LPN H said he/she did not see the incident but he/she heard hollering and then saw the Maintenance Director run downstairs. Then he/she saw them come upstairs and the Maintenance Director was asking them questions. He/She heard the residents telling the Maintenance Director about CNA G threatening to hit them with a cane. Resident #1 told the nurse he/she was mad the next day when he/she saw the CNA back at work because the staff member had threatened the residents the day before. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's progress notes, showed no documentation of him/her telling the nurse he/she was upset because a staff member who allegedly threatened him/her was working in the building. During an interview on 10/21/24 at 2:15 P.M., RN E said Resident #1 told him/her, he/she had an argument with CNA G because he/she was not supposed to be smoking. The resident said the CNA was disrespectful. The RN called the DON who said staff were not supposed to get in arguments with residents and told him/her to get statements. The resident wrote out a statement, but RN E could not make sense of it. The resident did not elaborate on what the CNA did that was disrespectful, and RN E did not ask. He/She just thought the resident was mad because he/she could not smoke. The CNA was shook up because he/she thought the resident was going to hit him/her with his/her cane. RN E sent CNA G home for the day. He/She was allowed to come back the next day, but the nurse talked to him/her about watching what he/she said and no verbal abuse. Review of a written statement by the Social Worker on 10/19/24, showed he/she was in the building attempting to complete social service obligations and did not hear or witness any interactions with any residents or staff members. During an interview on 10/21/24 at 10:00 A.M., the Social Worker said 10/19/24 was his/her off day, but he/she came in to make up some hours. The nurse from the fourth floor (RN E) asked him/her to gather statements from the residents because they were upset about an incident that happened in the smoking area. The Social Worker interviewed Resident #2 who said he/she might be in trouble because he/she told staff there were four of them and only one of him/her. The resident hated the new smoking policy because they used to be able to go out whenever they wanted. Resident #2 also told the CNA, I'm grown. Say that shit while you are walking. Resident #4 did not want to say what happened. He/She was just frustrated about being told what to do when they were adults. Resident #1 said the staff member got upset because he/she asked them to do something and they did not feel like he/she had a right to ask them to do it. The Social Worker assumed the staff member had left it alone. He/She did not ask the residents about the staff member's language or behavior. He/She knew they were upset but thought it was about not being able to smoke. During a telephone interview on 10/21/14 at 3:45 P.M., CNA G said a CNA stopped him/her and said residents were out in the smoking area and asked if he/she could ask them to come in. The residents were standing on the side of the building. The CNA knocked on the window and asked their names and if they were familiar with the smoke policy. One of the residents said, This is my f*cking house. I can do what I want. The CNA came out and told them they are not supposed to be smoking and they kept cussing him/her out. They said We will jump your ass. Resident #2 started walking up on him/her. There was another staff member outside, but he/she did not help at all. CNA G told the residents You are not going to beat my ass and started to yell for help. CNA G did not threaten them. The Maintenance Director came down and helped. CNA G did not even know these residents. He/She was not going to fight them. He/She thought they were intimidated by his/her size. He/She was allowed to come back the next day. No one in-serviced him/her on abuse/neglect after he/she came back. They just told him/her to stay on the fourth floor and away from the residents. Review of the investigation sent by the facility dated 10/25/24, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During the complaint survey on 10/21/24, the surveyor notified the Administrator that Resident #1 alleged verbal abuse from staff and that he/she provided a statement to the Charge Nurse. The verbal abuse was alleged to have taken place on 10/19/24; -The resident alleged he/she intervened in an incident between Certified Nurse's Aide G and Residents #2, #3 and #4 in which those residents were asked to smoke at the scheduled times; -The resident alleged the CNA said to him/her, I will f*ck you up; -The initial report and statements provided to the administrator on 10/19/24 were the residents were upset with the CNA due to his/her attempt to enforce the smoking policy; -The Director of Nursing (DON) asked the CNA to leave the facility until statements were gathered related to the incident; -Statements from staff claimed they did not have knowledge of any interactions between the parties; -At no time on 10/19/24, was the Administrator made aware of an allegation of verbal abuse; -Per the surveyor on 10/21/24, RN E was interviewed and stated Resident #1 was upset and provided a written statement related to the incident; -The nurse stated the resident did not allege verbal abuse from staff, and he/she did not read the statement; -The alleged statement was not received by the Administrator or DON; -Upon notification of the allegation, the DON obtained a statement from the resident and notified his/her physician; -The surveyor interviewed the Maintenance Director on 10/21/24 who stated the CNA admitted to him that he/she used inappropriate language towards the resident, however the statement the Maintenance Director provided in writing did not indicate this; -Other residents who were present at the time of the alleged abuse were interviewed. Resident #4 stated the CNA asked the residents for their names and asked they follow the smoking policy; -Resident #2 stated Nothing happened and refused to provide a written statement; -Resident #3 also declined to provide a statement; -Occurrence Resolution: Based on the evidence obtained as a result of the investigation, it is inconclusive as to whether or not verbal abuse occurred; -The CNA is no longer an employee; -No documentation of a statement from RN E; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation of interviews with other residents to determine if they had witnessed or experienced abuse from this CNA; -No documentation of further interviews with the Maintenance Director or LPN H to verify why their verbal accounts of the incident to the surveyor did not match the written statements; -No documentation of attempted further interviews with Residents #2, #3 and #4 to see if verbal abuse occurred after allegations were made. During an interview on 10/21/24 at 1:00 P.M., the DON said RN E called her on 10/19/24 around 1:00 P.M., and said a verbal altercation had occurred between the residents and staff, but he/she did not know what happened or who was involved. She then talked to the Maintenance Director who told her he overheard loud voices and came downstairs to see the residents advancing on the staff member. The DON had them get statements and told them to send the staff member home. It was her understanding the residents got aggressive with the staff member who originally told them it was not their smoke break time and went outside anyway. When CNA G approached them about it, Resident #2 told him/her It is four against one and we will beat the f*ck out of you. The residents did not report the staff member cursed or threatened them. None of the staff reported the staff member cursed or threatened the residents. She felt like the investigation was over at this point and notified the Administrator of this. She allowed the CNA to come back the next day to work his/her shift but told him/her to stay on the fourth floor and have nothing to do with the residents. During an interview on 10/21/24 at 3:50 P.M., the Administrator said the DON called and told her four residents were cursing at an aide and threatened to hit him/her with a cane. No one said anything about him/her cursing back. She thought the argument was about smoking times. Cursing at or threatening residents would be considered verbal abuse. The employee was sent home because the residents were so upset. If she had known the residents were alleging verbal abuse, he/she would not have been allowed to work until a thorough investigation had been completed. She expected her staff to follow the policy and report all incidents of verbal abuse to administration immediately so they could begin an investigation. The Maintenance Director should have told her the CNA admitted threatening the residents, and the LPN should have told her the resident told him/her the staff member threatened to hit him/her with a cane. This would have changed how the investigation was conducted and reported. MO00243836

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on observation, interview and record review, the facility failed to ensure resident care plans were updated and accurate to reflect resident needs. This failure affected one of three sampled residents, whose care plan did not identify the resident's increased need for staff assistance with activities of daily living (ADLs) after falling and fracturing his/her arm (Resident #10). The sample was three. The census was 77. Review of the facility's Baseline Care Plan Policy revised on 5/18/24, showed: -The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care: -Policy: The baseline care plan will: -Include the minimum healthcare information necessary to properly care for a resident, including but not limited to: -Physicians orders; -Therapy services; -Social services; -The admitting nurse or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders and discussion with the resident and resident representative, if applicable; -Interventions shall be initiated that address the resident's current needs including: -Any health and safety concerns to prevent decline or injury, such as elopement, fall or pressure injury risk; -Any identified needs for supervision, behavioral interventions and assistance with activities of daily living; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Mobility: Sit to lying: Independent; -Lying to sitting on side of bed: Independent. Resident completes the activity by him/herself with no assistance from helper; -Sit to stand: Independent. Resident completes the activity by him/herself with no assistance from helper; -Chair/bed to chair transfer: Independent. Resident completes the activity by him/herself with no assistance from helper; -Toilet transfer: Independent. Resident completes the activity by him/herself with no assistance from helper; -Tub/shower transfer: Independent. Resident completes the activity by him/herself with no assistance from helper; -Does resident use a wheelchair or a scooter: No; -Health conditions: -Pain effects on sleep: Nothing documented; -Pain effects on therapy activities: Nothing documented. Review of the resident's progress notes, showed the following: -On 9/13/24 at 7:30 A.M., the resident said he/she had a fall and was able to pick him/herself up off the floor. Upon assessment, the resident's right arm was painful to the touch and swollen. Staff placed a call to the resident's physician. An order was received to send the resident to the emergency room (ER) for evaluation and treatment. The resident was able to move all other extremities without difficulty. Vital signs: Temperature 98 degrees (normal ranges from 97.5 Fahrenheit (F) to 98.9), blood pressure 124/72 (normal is 120 or less systolic (the top number in a blood pressure reading measures the pressure in the arteries when the heart beats) and 80 or less diastolic (the resting phase of the heart's cycle when the heart's chambers are relaxed and filled with blood), oxygen saturation level 97 (normal ranges between 95% and 100%). At 7:40 A.M., staff called 911. At 8:10 A.M., emergency transfer staff were in facility to transfer resident. At 12:40 P.M., the resident returned from the ER with an appointment to see ortho (orthopedic doctor specializes in the management of pain related to the musculoskeletal system) and with a splint to be worn when up, until appointment with ortho. At 12:45 P.M., staff called the resident's physician to inform him of the resident's return. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's hospital records, dated 9/13/24, showed: -Fall, unclear mechanism. Right upper extremity injury. Facial involvement; -Final diagnosis: Closed right (RT) humeral fracture (a break in the upper arm bone), spiral (bone broken in a twisting motion)displaced (a displaced fracture means the pieces of the bone moved so much, a gap formed around the fracture); -Relevant imaging results show RT humeral fracture and contusion (bruise) without fracture to nasal bone; -Patient sent back to nursing home with sling and follow up with ortho, ENT (ear, nose and throat specialist) and physician. Review of the resident's care plan updated 9/13/24, showed: -The resident required limited supervision with ADL tasks; -Problem: Nine plus medications; -Goals: Resident will experience full benefit from prescribed medication and remain free of adverse reactions through next review; -Interventions: Administer medications as directed. See Physician Order Sheet; -Problem: Potential for decline in activity; -Interventions: Encourage socialization with others as tolerated. Activities will remind/escort resident as needed to activities of choice. Resident enjoys working puzzles, socializes with others and has contact with family. -No documentation of limitations of range of motion or assistance needed to participate in activities; -Problem: Potential for self care deficit related to ambulates with wheelchair; -Goals: Resident will maintain current level of function and be clean and well groomed through next review; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Resident ambulates around the facility with wheelchair. Gait usually abnormal. Positions independently. Transfers without assistance. Dresses independently. Feeds self. Monitor consumption report. Toilets self. Continent. Urinary dribbles, wears bladder pads. Personal care done independently. Showers independently. Bedtime routine completed independently. -On 9/13/24, resident had a fall in his/her room. Complained of pain in right arm and sent to ER to evaluate and treat. Returned with right arm and nose fractures. -No documentation of additional assistance needed to dress, transfer, toilet and shower; -Problem: Potential for alteration in cognitive function; difficulty making needs known. Short/long term memory impairment, difficulty with daily decision making. On 8/22/24, the resident continued to make his/her needs known; -Interventions: Administer medications per physicians' orders. Monitor for cognitive change and report; -Problem: Potential for change in usual bowel movement routine; -Interventions: Encourage fluids and consumption. Administer medications per physician's orders. On 8/22/24, the resident uses the bathroom on his/her own. Remind him/her to inform staff of change in normal routine. -No documentation of additional assistance needed to use the bathroom; -Problem: Potential for weight loss/gain; -Interventions: Provide diet/supplements, health shakes per physicians' orders. Eats independently in dining room. -No documentation of increased staff assistance needed to cut food and open items; -Problem: Potential for falling. On 9/13/24, the resident reported he/she had fallen and complained of right arm pain. Staff informed physician. New order received to send to emergency room to evaluate and treat; -Interventions: Monitor for gait and balance. Keep area free of clutter. Encourage rest periods. Assist with transfers as needed. Physical therapy/occupational therapy per physicians orders. -No documentation of new precautions to take with resident unable to use right arm; -Problem: Potential for pain; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Educate resident on signs and symptoms of lethargy due to administration of pain medications. Administer routine pain medications per physician's orders. Monitor for effectiveness of pain management and alert physician as needed. Monitor for verbal/nonverbal indicators of pain. Pain management consultation as needed. Pain assessment quarterly. See assessment in chart. No documentation of unhealed fractured arm or pain assessment after arm fracture; -Problem: Potential for impaired skin integrity; -Interventions: On 8/22/24, staff continues weekly to assess skin integrity with no issues. Provide treatment to affected areas as directed. Inform physician of any changes. Monitor consumption/report decline. Weekly skin assessments on Mondays. New concerns will be reported to physician. -No documentation of brusing and swelling in right arm, both hands and lower extremities or what interventions staff would provide for these. Review of the resident's progress notes, on 9/14/24, no time noted, showed the resident remained on IFU (incident follow up) related to his/her fall. He/She was in no apparent distress. Staff would continue to monitor. The resident's arm remained in the sling. Staff administered pain medication three times during the shift. It was effective within an hour. There was bruising and swelling to the right arm. Staff provided assistance with the resident's activities of daily living. Vital signs were temperature 98 degrees, blood pressure 132/70; -On 9/15/24 between 7:00 P.M. and 7:00 A.M., the resident remained on IFU. He/She had not complained of pain or distress at the time. Vital signs: Blood pressure 138/60, pulse 78, respirations 20, temperature 98 degrees. At 7:00 P.M., the resident remained on observation, seated in his/her wheelchair. The staff administered pain medication three times during the shift. It was effective within an hour. Staff noted no signs of acute distress. The resident did have bruising on the bridge of his/her nose and the right arm. Staff provided assistance with all ADLs; -On 9/16/24 between 7:00 P.M. and 7:00 A.M., the resident remained on IFU/fall with injury. He/She had significant bruising to the entire right arm related to the fracture and has a sling in place. Vital signs were: Blood pressure 140/70, pulse 68, respirations 20 and temperature 98 degrees. At 4:30 P.M., the resident was up in his/her wheelchair propelling him/herself. No complaints of pain or discomfort at the time. His/Her arm was discolored and edematous (swelling); -On 9/17/24, no time noted, the resident's arm was extremely swollen and staff noted discoloration from shoulder to hand. His/Her hand was warm to the touch and his/her radial (wrist) pulse was weak. Staff notified the resident's physician and sent the resident to the ER for evaluation; -On 9/18/24 at 12:20 A.M., the resident returned to the facility and no issues were found with his/her venous Doppler (ultrasound test that uses sound waves to examine the circulation of blood in veins). There were no changes on the x-ray of his/her right hand since the initial x-ray. The resident denied pain. At 6:15 A.M., staff checked on the resident who voiced no pain. At 7:10 A.M., the resident would not get up to use the restroom or attempt to use his/her call light. His/Her entire bed was soaked. Staff assisted him/her with care; -On 9/19/24, no time noted, the resident continued to wear an arm sleeve. Staff encouraged him/her to elevate his/her arm. No complaints of pain at the time. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's x-ray dated 9/19/24, showed: -Appointment information: Diagnosis: Closed fracture of shaft of right humerus with delayed healing, unspecified fracture morphology, subsequent encounter; -Unspecified fracture of shaft of humerus, right arm; -Findings: A comminuted and angulated proximal right humeral shaft fracture (a serious injury where the upper part of the right upper arm bone is broken into multiple pieces and is significantly angled out of alignment occurring near the shoulder joint on the shaft of the bone) is unchanged. There is a displaced butterfly fragment (a triangular piece of bone that has moved out of its original position due to the injury, resembling the shape of a butterfly's wings); -Follow up with hospital orthopedics. Review of the orthopedic physician's office visit notes dated 9/19/24, showed: -The resident had been having right upper extremity pain for nine days; -The resident had an injury to the shoulder after a fall; -The resident complained of pain during the day and night and had sleep disturbances; -The resident complained of loss of strength and loss of motion; -At this point, they had tried treatment options including activity modification, anti inflammatory medications, acetaminophen (pain reliever) and bracing; -The symptoms were not improving with conservative measures; -Patient reported satisfaction: -Current state: No; -Prior state: No; -PROMIS (Patient reported outcomes measurement information system measures health status from the patient's perspective) upper extremity score: 15 (severe dysfunction); -PROMIS pain score 76 (severe); -No current facility administered medication on file prior to visit; -Physical exam: Splint removed; -Skin: Diffuse healing ecchymosis (a widespread bruise, where the discoloration from leaked blood under the skin is spread out over a large area, rather than localized in one spot); (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Right upper extremity: Tenderness along the arm. Mobile fracture fragments (pieces of broken bone); -X-ray showed a comminuted shaft fracture (the bone breaks into several pieces) with a long spiral fragment; -Displaced comminuted right proximal humerus fracture (a severe break in the upper part of the arm where the bone shatters into multiple pieces and has shifted out of the normal position); -Plan: Therapy as tolerated to improve range of motion of wrist and hand. Another x-ray in a week to see if better alignment. Review of the resident's physical therapy (PT) notes dated 10/1/24 through 12/18/24, showed: -Needed supervision or touching assistance to roll left and right; -Transfers: Needed partial to moderate assistance to sit to stand; Needed partial/moderate assistance from chair to bed to chair; Toilet transfer-not applicable; -Reason for skilled services: Continued PT services are necessary in order to facilitate independence with all functional ability, improve dynamic balance, increase lower extremity range of motion and strength and minimize falls in order to enhance patient's quality of life by an improved ability to decrease level of assistance from caregivers. Due to documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for falls and further decline in function; -Current referral: Reason for referral: Due to new onset decline in functional ability and functional strength, increased fall risk, increased need for assistance with ADLs and reduced functional balance; -Continued skill: Due to the documented physical impairments and associated functional deficits without skilled therapeutic intervention, the patient is at risk for decreasing ability to return to prior level of assistance, decreased ability to return to living environment, decreased ability to return to prior level of supervision, decreased circulatory function, falls, muscle atrophy and further decline in function. Review of the resident's Occupational Therapy (OT) notes from 10/1/24 through 12/18/24, showed: -Toileting hygiene: Substantial/maximal assistance; -Lower body dressing: Substantial/maximal assistance; -Upper body dressing: Substantial/maximal assistance; -Toilet transfer: Partial/moderate assistance; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Prior to onset: Independent. Baseline on 10/1/24: Substantial/maximal assistance; -Current referral: Patient referred to OT due to new onset of decrease in functional mobility, decrease in strength, decreased coordination, increased need for assistance from others, reduced ADL participation, reduced static balance and dynamic balance and falls/fall risk; -Prior levels of function: Self care-Independent. Functional cognition -Independent. During an interview on 12/19/24 at 12:15 P.M., the facility's physical therapy manager said the resident was referred to them in October and was still on their caseload. They were working to teach him/he how to function with one arm. The resident needed staff assistance with transferring, toileting, dressing and showering. They were not working with his/her right arm because it was still fractured and in a sling. Review of the resident's care plan, in use at the time of the investigation and reviewed on 12/18/24, showed: -The resident required limited supervision with ADL tasks. -No updated information regarding needing maximum assistance with transferring, dressing, toileting and showering; -Problem: Potential for decline in activity; -Interventions: Encourage socialization with others as tolerated. Activities will remind/escort resident as needed to activities of choice. Resident enjoys working puzzles, socializes with others and has contact with family. -No documentation of limitations of range of motion or assistance needed to participate in activities; -Problem: Potential for self care deficit related to ambulates with wheelchair; -Goals: Resident will maintain current level of function and be clean and well groomed through next review; -Interventions: Resident ambulates around the facility with wheelchair. Gait usually abnormal. Positions independently. Transfers without assistance. Dresses independently. Feeds self. Monitor consumption report. Toilets self. Continent. Urinary dribbles, wears bladder pads. Personal care done independently. Showers independently. Bedtime routine completed independently. -No documentation of additional assistance needed to dress, transfer, toilet and shower; -Problem: Potential for weight loss/gain; -Interventions: Provide diet/supplements, health shakes per physicians' orders. Eats independently in dining room. (continued on next page)

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	265668	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No documentation of increased staff assistance needed to cut food and open items; -Problem: Potential for pain; -Interventions: Educate resident on signs and symptoms of lethargy due to administration of pain medications. Administer routine pain medications per physician's orders. Monitor for effectiveness of pain management and alert physician as needed. Monitor for verbal/nonverbal indicators of pain. Pain management consultation as needed. Pain assessment quarterly. See assessment in chart. -No documentation of pain assessment after arm fracture; -Problem: Potential for impaired skin integrity; -Interventions: Provide treatment to affected areas as directed. Inform physician of any changes. Monitor consumption/report decline. Weekly skin assessments on Mondays. New concerns will be reported to the physician. -No documentation of brusing and swelling in right arm, both hands and lower extremities or what interventions staff would provide for these. Observation and interview on 12/18/24 at 2:00 P.M., showed the resident sat in a wheelchair in the hallway with a sling on his/her right arm. His/Her head was slumped down, and he/she appeared to be tired. He/She said his/her arm was bruised in a fall a couple of weeks ago. He/She could not remember the details of the fall or missing his/her surgery date. The resident said he/she had been in pain for several months. It did not hurt all of the time, mostly when he/she had to move the arm or turned the wrong way. It was usually at a level 3 out of 5. He/She was not able to do the things he/she used to do, and it made him/her sad. During interviews on 12/18/24 at 12:45 P.M. and at 2:20 P.M., Licensed Practical Nurse L said the resident needed more help now with transferring, showering and dressing. He/She used to use a walker before the fall and now needed to use a wheelchair. During an interview on 12/18/24 at 2:10 P.M., Certified Nurse's Aide (CNA) F said the resident cannot move his/her arm very well. The CNA had to help the resident transfer out of bed into his/her wheelchair, shower, dress and toilet. The resident could not do these things by him/herself since the fall. Review of an email sent by the facility Administrator on 12/26/24, showed the MDS coordinator was responsible for updating the care plans. The expectation for updating these records was to obtain any records they could locate. During an interview on 12/30/24 at 12:15 P.M. the MDS Coordinator, who also serves as the facility's Care Plan Coordinator, said care plans are developed in collaboration with facility staff, the resident, and their families on admission, annually, and with a change in condition. She updated the resident's care plan in September 2024 when the resident had a fall and thought she included the additional assistance from staff needed with his/her ADLs. She probably assessed him/her for pain after he/she came back from the hospital with a fractured arm, but he/she was not sure and could not find the documentation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/24 at 12:40 P.M., the Interim Director of Nursing said the resident's care plan should have been updated in 9/24 when he/she came back from the hospital with a fractured arm to reflect his/her need for additional staff assistance. It was important to update the care plan so staff knew how to care for the resident. During interviews on 12/18/24 at 3:00 P.M. and on 12/30/24 at 1:00 P.M., the Administrator said the MDS Coordinator was responsible for updating the care plan. The care plan should be updated when there is a change in condition and the resident required more assistance. A pain assessment should have been done after the resident returned from the hospital and interventions added to the care plan if the resident was experiencing pain. During an interview on 12/18/24 at 3:00 P.M., the resident's physician office representative said the resident would not be independent with his/her ADLs with a fractured arm and using a sling. The facility should have updated his/her care plan to reflect this loss of mobility and need for increased assistance as soon as he/she came back from the hospital. MO00246748

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on interview and record review, the facility failed to ensure a resident (Resident #10) kept all appointments with the orthopedic surgeon after an unwitnessed fall resulting in a fracture of his/her right arm on 9/13/24. Delay of treatment has caused pain and a decrease in his/her ability to perform activities of daily living (ADLs). The sample was three. The census was 77. Review of the facility's Resident Appointment policy, updated on 8/24, showed: -Purpose: To ensure all appointments and follow-up appointments (as needed) are scheduled. Residents will be taken to all scheduled appointments (barring emergency circumstances that require rescheduling). The facility is responsible in assisting with appointment management and scheduling/coordination of transportation (if requested/needed); -Procedure: -Nursing staff to assist with scheduling appointments and follow-up if needed; -Nursing staff to communicate transportation to social services director (SSD) and SSD will set up transportation for the scheduled appointment; -The SSD or designee is responsible for scheduling any needed follow-up appointments; -Communication, appointments, follow ups, concerns, etc. will be documented appropriately. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/24, showed: -Cognitively intact; -Independent with ADLs; -No history of pain; -No history of falls since admission or prior assessment; -Diagnoses included other specified disorders of bone density and structure, and muscle weakness. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes, showed the following: -On 9/13/24 at 7:30 A.M., the resident said he/she had a fall and was able to pick him/herself up off the floor. Upon assessment, the resident's right arm was painful to the touch and swollen. Staff placed a call to the resident's physician. An order was received to send the resident to the emergency room (ER) for evaluation and treatment. The resident able to move all other extremities without difficulty. At 7:40 A.M., staff called 911. At 8:10 A.M., emergency transfer staff were in facility to transfer resident. At 12:40 P.M., the resident returned from the ER with an appointment to see ortho (orthopedic doctor specializes in the management of pain related to the musculoskeletal system) and with a splint to be worn when up, until appointment with ortho. At 12:45 P.M., staff called the resident's physician to inform him of the resident's return. Review of the resident's hospital records, dated 9/13/24, showed: -Fall, unclear mechanism. Right upper extremity injury. Facial involvement; -Final diagnosis: Closed right (RT) humeral fracture (a break in the upper arm bone), spiral (bone broken in a twisting motion)displaced (a displaced fracture means the pieces of the bone moved so much, a gap formed around the fracture); -Relevant imaging results show RT humeral fracture and contusion (bruise) without fracture to nasal bone; -Patient sent back to nursing home with sling and follow up with ortho, ENT (ear, nose and throat specialist) and physician. -No documentation in hospital notes to indicate when surgery or follow up appointments were made. Review of the resident's progress notes, on 9/14/24, no time noted, showed the resident remained on IFU (incident follow up) related to his/her fall. The resident's arm remained in the sling. Staff administered pain medication three times during the shift. It was effective within an hour. There was bruising and swelling to the right arm. Staff provided assistance with the resident's activities of daily living. -On 9/15/24 between 7:00 P.M. and 7:00 A.M., the resident remained on IFU. The staff administered pain medication three times during the shift. It was effective within an hour. The resident did have bruising on the bridge of his/her nose and the right arm. Staff provided assistance with all ADLs; -On 9/16/24 between 7:00 P.M. and 7:00 A.M., the resident remained on IFU/fall with injury. He/She had significant bruising to the entire right arm related to the fracture and has a sling in place. His/Her arm was discolored and edematous (swelling); (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 9/17/24, no time noted, the resident's arm was extremely swollen and staff noted discoloration from shoulder to hand. His/Her hand was warm to the touch and his/her radial (wrist) pulse was weak. Staff notified the resident's physician and sent the resident to the ER for evaluation; -On 9/18/24 at 12:20 A.M., the resident returned to the facility and no issues were found with his/her venous Doppler (ultrasound test that uses sound waves to examine the circulation of blood in veins). There were no changes on the x-ray of his/her right hand since the initial x-ray. The resident denied pain. Review of the orthopedic physician's office visit notes dated 9/19/24, showed: -The resident had been having right upper extremity pain for nine days; -The resident had an injury to the shoulder after a fall; -The resident complained of pain during the day and night and had sleep disturbances; -The resident complained of loss of strength and loss of motion; -At this point, they had tried treatment options including activity modification, anti inflammatory medications, Tylenol and bracing; -The symptoms were not improving with conservative measures; -PROMIS (Patient reported outcomes measurement information system measures health status from the patient's perspective) upper extremity score: 15 (severe dysfunction); -PROMIS pain score 76 (severe); -No current facility administered medication on file prior to visit; -Physical exam: Splint removed; -Skin: Diffuse healing ecchymosis (a widespread bruise, where the discoloration from leaked blood under the skin is spread out over a large area, rather than localized in one spot); -Right upper extremity: Tenderness along the arm. Mobile fracture fragments (pieces of broken bone); -X-ray showed a comminuted shaft fracture (the bone breaks into several pieces) with a long spiral fragment; -Displaced comminuted right proximal humerus fracture (a severe break in the upper part of the arm where the bone shatters into multiple pieces and has shifted out of the normal position); -Plan: Therapy as tolerated to improve range of motion of wrist and hand. Another x-ray in a week to see if better alignment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's monthly physician's notes, dated 9/19/24, showed: -The chief complaint was a right humerus fracture; -The resident had new or worsening medical problems over the last month; -The resident was feeling tired or poorly; -The resident had a fall in the shower and complained of right arm pain. Sent to the hospital on 9/18/24 and found to have a right humerus fracture. Ortho consulted and to follow up as outpatient. The resident returned to the nursing home within hours. He/She was going to follow up with ortho today for surgery. His/Her right arm was ace wrapped and his/her hand was swollen; -Resident reported pain and feeling tired or poorly; Review of the resident's care plan updated 9/13/24, showed: -Problem: Potential for self care deficit related to, ambulates with wheelchair; -Goals: Resident will maintain current level of function and be clean and well groomed through next review; -Interventions: Resident ambulates around the facility with wheelchair. Gait usually abnormal. Positions independently. Transfers without assistance. Dresses independently. Feeds self. Monitor consumption report. Toilets self. Continent. Urinary dribbles, wears bladder pads. Personal care done independently. Showers independently. Bedtime routine completed independently. On 9/13/24, resident had a fall in his/her room. Complained of pain in right arm and sent to ER to evaluate and treat. Returned with right arm and nose fractures; -Problem: Potential for falling. On 9/13/24, the resident reported he/she had fallen and complained of right arm pain. Staff informed physician. New order received to send to emergency room to evaluate and treat; -Interventions: Monitor for gait and balance. Keep area free of clutter. Encourage rest periods. Assist with transfers as needed. Physical therapy/occupational therapy per physician's orders; -Problem: Potential for pain; -Interventions: Educate resident on signs and symptoms of lethargy due to administration of pain medications. Administer routine pain medications per physician's orders. Monitor for effectiveness of pain management and alert physician as needed. Monitor for verbal/nonverbal indicators of pain. Pain management consultation as needed. Pain assessment quarterly. See assessment in chart. Review of the resident's progress notes, showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 9/23/24 between 7:00 A.M. and 7:00 P.M., staff notified the resident's physician regarding swelling, redness and warmth in the right arm. A new order was received for doxycycline (used to treat infection) 100 milligrams (mg), twice a day by mouth for ten days and lasix (used to help reduce excess fluid in the body) 40 mg, one time a day by mouth for ten days. The resident's sling remained intact and staff encouraged him/her to sleep on his/her left side. No signs of acute distress noted. -On 9/24/24 between 7:00 A.M. and 7:00 P.M., the resident's sling remained in place. His/Her arm and fingers remained edematous (swollen); -On 10/23/24, the resident was up and ready for his/her appointment with his/her paperwork. The resident was scheduled for surgery; -No documentation if surgery occurred or why it did not; -No documentation of notifications to physician or family representative; -No documentation of rescheduling of surgery. Review of the resident's monthly physician visit notes dated 11/1/24, showed: -Resident feeling tired or poorly; -Has chronic pain. Seen for follow up. Complained of left hip pain as well; -Seen in wheelchair, wearing a sling on upper right extremity. fell in September suffering a right proximal comminuted fracture and saw ortho. Surgery was canceled and rescheduled. Labs done as pre-operation (pre-op) and they cleared him/her. Review of the orthopedic physician's appointment records for the resident on 12/18/24, showed on 9/26/24, the resident's orthopedic appointment with the physician was canceled. Review of the resident's progress notes, showed no documentation of missed appointment on 9/26/24. Review of the orthopedic physician's appointment records for the resident on 12/18/24, showed on 10/3/24, the resident did not show up for his/her appointment. (There is nothing in the progress notes to show the surgery was rescheduled.) Review of orthopedic physician office visit notes dated 10/10/24, showed: -Chief complaint: Right upper extremity pain; -The resident was unable to follow up since last visit and they had been unable to successfully get medical clearance for surgery until then; -Physical exam: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Right upper extremity: Tenderness along the arm. Mobile fracture fragments. Shoulder and elbow range of motion not attempted due to pain. There was swelling over the elbow forearm and hand and weak elbow flexion and extension (motion of bending and straightening the elbow); -Plan: Resident agreed to proceed with surgery in the form of right humerus, open reduction and internal fixation (surgical procedure to repair broken humerus bone in upper arm. The surgeon makes an incision to realign the bone and uses hardware like screws, plates, rods or pins to hold the bone together); -The surgery would not be scheduled until there was medical clearance. Review of the resident's progress notes, showed: -On 10/14/24 at 2:50 P.M., the resident's surgeon's office called related to his/her 10/23/24 surgery. They needed surgery clearance. Staff called the resident's physician who stated they would fax the letter on 10/15/24; -On 10/23/24, the resident was up and ready for his/her appointment with his/her paperwork; -No further documentation of why surgery was canceled and/or rescheduled. Review of the resident's physician's appointment records, showed: -On 10/23/24, the resident was scheduled for surgery; -On 11/8/24, the resident's follow up appointment was canceled because the surgery did not occur; -On 12/12/24, the resident was a no show for his/her appointment. Review of a transportation note dated 12/12/24, provided by the facility on 9/18/24, showed the resident's 12/12/24, appointment with the orthopedic physician was canceled because transportation failed to show. During interviews on 12/18/24 at 12:45 P.M. and at 2:20 P.M., Licensed Practical Nurse L said he/she was working on 12/12/24, and the transportation company did show up but left because the resident was not downstairs ready to go. He/She did not remember getting a call from the physician's office or rescheduling an appointment for him/her. The resident needed more help now with transferring, showering and dressing. He/She used to use a walker before the fall and now needed to use a wheelchair. During an interview on 12/18/24 at 1:10 P.M., the SSD said she sat up the transportation for resident appointments. The resident was supposed to go to the hospital for some appointments, but the SSD did not know the resident missed them. The SSD only had documentation for the 10/10/24 appointment that the resident made, the 10/23/24 surgery date that was missed and the 12/12/24 appointment that was missed. The SSD did not know about the other appointments and did not remember setting up transportation for them. The nurse would have made those appointments, and the SSD did not know why she was not given the information. The nurse was no longer working at the facility. Review of the resident's monthly physician visit notes dated 12/16/24, showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Resident feeling tired or poorly; -Has increased edema right upper extremity and both lower extremities. Was in sling, not using much. Will increase Lasix to two times a day and get labs; -Resident reported lower back pain, left hip joint pain, joint pain in both knees, muscle stiffness and stillness localized to one or more joints; -Not well appearing; -Comminuted right proximal humerus fracture. Now in sling. Cleared for surgery if needed. During an interview on 12/18/24 at 2:00 P.M., the resident said he/she had been in pain for several months. It did not hurt all of the time, mostly when he/she had to move the arm or turned the wrong way. It was usually at a level 3 out of 5. He/She was not able to do the things he/she used to do and it made him/her sad. He/She just wanted to have the surgery and get the arm fixed so he/she could take care of him/herself again. He/She was supposed to get surgery but when he/she got down to the lobby, the transportation people had left. This happened a lot. He/She tried to get there as soon as possible, but it took a while to get on the elevator and get downstairs. It was very frustrating because he/she just wanted to feel good again. During an interview on 12/19/24 at 12:15 P.M., the facility's physical therapy manager said the resident was referred to them in October and was still on their caseload. They were working to teach him/he how to function with one arm. The resident needed staff assistance with transferring, toileting, dressing and showering. They were not working with his/her right arm because it was still fractured and in a sling. Review of a note sent by the resident's orthopedic physician's office on 12/18/24, showed the office tried to make the appointment with the nursing facility but had not seen the resident since 10/10/24, and no one would call them back. During an interview on 12/18/24 at 2:10 P.M., Certified Nurse's Aide (CNA) F said he/she noticed brusing on the resident that morning during his/her shower. He/She did not notice it earlier since the resident was wearing long sleeves. The bruising was not there the prior week when he/she gave him/her a shower. The resident fell a few months ago and had some bruising and pain since them. He/She cannot move his/her arm very well. The CNA had to help the resident transfer out of bed into his/her wheelchair, shower, dress and toilet. The resident could not do these things by him/herself since the fall. During an interview on 12/18/24 at 2:00 P.M., the resident said he/she had a bruise on his/her arm from falling a couple of weeks ago. He/She did not remember the actual fall in 9/24. He/She is getting very confused and cannot remember things as well anymore. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/18/24 at 2:15 P.M., the orthopedic physician's nurse, said the resident was originally scheduled to have surgery on 10/10/24, and the resident did not have the approval from the physician's office to do it. They rescheduled the surgery for 10/23/24 and then could not do it because the resident had eaten that morning. They attempted to call the facility several times to set up an appointment to have the resident come into the outpatient clinic, but no one would help them set up the appointment. They finally got one set up for 12/12/24, and the resident did not show up. No one called the clinic to let them know the resident was not coming. They had been trying to set up another appointment, but no one would return their calls. During an interview on 12/18/24 at 3:00 P.M., the resident's physician office representative said they were aware the resident was scheduled for surgery and missed it on 10/23/24. The physician cleared the resident for surgery, and the physician thought the facility was rescheduling it. The facility did not notify the office the resident missed more appointments or the resident continued to have pain. They should have notified them about this. They rescheduled another x-ray for the resident because the facility reported he/she was having pain and swelling. The facility did not notify them about the new brusing on his/her right arm. They did not think the resident fell because he/she would not have been able to get him/herself up off the floor. It was probably due to complications with the fracture and should have been noticed prior to 12/18/24 if it was older brusing and reported to them. During an interview on 12/19/24 at 11:50 A.M., the resident's orthopedic surgeon said the resident's arm was broken and could not heal on its own. The resident had lost mobility in his/her upper extremities because he/she could not use his/her arm. Their office tried to set up an appointment with the resident several times. He was concerned because the resident was expressed being in a lot of pain when he saw him/her and might not be expressing this pain to the staff. The x-ray they took did not indicate a new break but the old fracture could be moving or he/she might have damaged it again and it was causing the swelling and bruising. The resident might never regain his/her mobility back. That is why it is so important to get the surgery done before any more damage occurs. No one from the facility notified his office that the resident continued to have bruising and swelling in his/her arm and hands. The arm would not get better unless the resident had the surgery, and he/she would continue to have pain. They had referred him/her to physical therapy to increase the strength in the arm, but it would not help if he/she could not move his/her arm. During an interview on 12/18/24 at 1:00 P.M., the corporate nurse said they had been having problems with the transportation company. They would come late or not show up at all. The charge nurse is responsible to set up appointment and once this is done, he/she will give the information to the SSD who will set up transportation. If the resident misses an appointment, the charge nurse should reach out to the physician's office to reschedule it. All of this information should be documented in the resident's medical record. She was not aware of why the resident missed his/her surgery date or that he/she missed several follow up appointments. Review of the resident's hospital records, dated 12/18/24, showed: -The patient presented with complaint of right arm pain; -The patient fell and developed right humeral fracture on (continued on next page)

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	265668	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0684 Level of Harm - Actual harm Residents Affected - Few	9/13/24; -Patient scheduled to be seen by ortho as outpatient, but his/her appointments were not kept by the nursing home; -Since fall, he/she could not follow up with orthopedic surgery; -As patient has difficulty moving right arm for a couple of months and has not seen the orthopedic doctor recently, he/she decided to come to the emergency room and be seen by ortho; -Patient was admitted for further evaluation and management. Review of the resident's X-ray results dated 12/19/24, showed a comminuted displaced multipart fracture of the proximal humerus is noted with significant displacement of fracture fragments with foreshortening (due to the positioning of the bone on the x-ray, the bone appears shorter than it actually is on the image, indicating the fracture fragments might be telescoped (one [NAME] is sliding partially inside another bone) into each other). During an interview on 12/27/24 at 1:00 P.M., the former Director of Nursing (DON) said he/she knew the resident was scheduled for surgery in October and it had to be rescheduled because the resident ate that morning. Staff should not have fed him/her. The charge nurse was responsible for rescheduling the surgery and letting the SSD know so she could set up transportation. No one ever told the DON the resident was still missing appointments. The staff should have reported the missed appointments so the DON could find out what happened and follow up. During interviews on 12/18/24 at 2:40 P.M. and at 4:00 P.M., the Administrator said she just started working at the facility a couple of months ago. She was not here when the resident fractured his/her arm and did not know he/she had missed the surgery. The resident should have gotten his/her surgery by now. When the first surgery was missed, they should have immediately rescheduled another one and made sure transportation was available. She knew the resident missed his/her transportation on 12/12/24 but thought it was just a regular appointment. She would have expected staff to document when appointments were made and/or missed and for them to follow up setting up a new appointment. The nurses were responsible for setting the appointments and then once the appointment was made, they would notify the SSD who would set up transportation. The staff should have had the resident ready to go when transpiration arrived. MO00246748

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40865 Based on observation, interview, and record review, the facility failed to consistently assess pain or provide treatment in a timely manner for one resident (Resident #10) who fell and fractured his/her arm on 9/13/24. The resident missed a surgery date on on 10/23/24 after staff fed the resident, which resulted in the surgery being canceled. The facility failed to ensure the resident was seen by his/her orthopedic physician despite several attempts by the office to set up appointments since the postponed surgery or set up a new date for the surgery. The facility also failed to complete a new pain assessment after the resident's arm was fractured. These failures resulted in pain and a loss of mobility for the resident. The sample was three. The facility census was 77. Review of the facility's Pain Management policy revised on 6/26/24, showed: -Purpose: The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive care plan and the resident's goals and preferences; -Policy: The facility will utilize a systematic approach for recognition, assessment and monitoring of pain; -Recognition of pain: In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: --Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated; --Evaluate the resident for pain and the cause(s) upon admission, during ongoing assessments and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain); --Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice and the resident's goals and preferences; -Facility staff will observed for nonverbal indicators which may (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	indicate the presence of pain. These indicators include but are not limited to: --Loss of function or inability to perform activities of daily living (ADLs) e.g. rubbing a specific location of the body, or guarding a limb or other body parts; --Behaviors such as: Resisting care, irritability, depressed mood or decreased participation in usual physical and/or social activities; --Skin conditions; -Pain assessment: The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain; -Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g. nurses, practitioner, pharmacists and anyone else with direct contact with the resident) may necessitate gathering the following information as applicable to the resident; --History of pain and its treatment (including non-pharmacological, pharmacological and alternative medicine treatment and whether or not each treatment has been effective; --Asking the resident to rate the intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident; --Reviewing the resident's current medical conditions; --Identifying key characteristics of the pain: --Duration of pain; --Frequency; --Location; --Timing; --Pattern (consistent or intermittent); (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	--Radiation of pain; -Obtaining descriptors of the pain; -Identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain; -Impact of pain on quality of life (e.g. sleeping, functioning, appetite and mood); -Current prescribed pain medications, dosage and frequency; -The resident's goals for pain management and his/her satisfaction with the current level of pain control; -Physical and psychosocial issues that might be causing or exacerbating the pain; -Pain management and treatment: -Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission; -Factors influencing the choice of treatments include: -The cause, location and severity of resident's pain; -The resident's current medical condition; -The resident's current medications; -The resident's desired level of relief and tolerance for adverse consequences; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Potential benefits, risks and adverse consequences of medications; -Available treatment options; -Non-pharmacological interventions will include but are not limited to: -Environmental comfort measures; -Loosening any constrictive bandage, clothing or device; -Applying splinting (e.g. pillow or folded blanket); -Physical modalities (e.g. cold compress, warm shower/bath, massage, turning or repositioning); -Cognitive/behavioral interventions (e.g. music, relaxation techniques, activities, diversions, teaching the resident coping techniques and education about pain); -Pharmological interventions will follow a systematic approach for selecting medications and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain; -Monitoring, reassessment and care plan revision: -Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences such as: -Tolerance; -Physical dependence; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Increased sensitivity to pain; -Constipation; -Sleepiness, dizziness and/or confusion; -Depression; -If re-assessment findings indicate pain is not adequately controlled, the pain management regimen and plan of care will be revised as indicated. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/22/24, showed: -Cognitively intact; -No behaviors or rejection of care; -Functional Limitation in Range of Motion: No Independent with all ADLs; -No pain; -No falls since admission or prior assessment. Review of the resident's progress notes, showed on 9/13/24 at 7:30 A.M., the resident told staff he/she fell and was able to pick him/herself up off the floor. Upon assessment the resident's right arm was painful to the touch and swollen. Staff placed a call to the resident's physician. An order was received to send the resident to the emergency room (ER) for evaluation and treatment. The resident able to move all other extremities without difficulty. At 7:40 A.M., staff called 911. At 8:10 A.M., emergency transfer staff in facility to transfer resident. At 12:40 P.M., the resident returned from the ER with a appointment to see the ortho (orthopedic physician) and with splint to be worn when up until appointment with ortho. At 12:45 P.M., staff called the resident's physician to inform him of his/her return. Review of the resident's hospital records, dated 9/13/24, showed: -Fall unclear mechanism. Right upper extremity injury. Facial involvement; -Final diagnosis: Closed right (RT) humeral fracture (a break in the upper arm bone), spiral (bone broken in a twisting motion) displaced (a displaced fracture means the pieces of the bone moved so much a gap formed around the fracture); (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Relevant imaging results show RT humeral fracture and contusion (bruise) without fracture to nasal bone; -Patient sent back to nursing home with sling and follow up with ortho, ENT (ear, nose and throat specialist) and physician. Further review of the resident's progress notes showed: -On 9/14/24, no time noted, the resident remained on incident follow-up (IFU) related to his/her fall. He/She was in no apparent distress. Staff would continue to monitor. His/Her call light was in his/her reach and bed was in the lowest position. At 7:00 P.M., the resident's family were in the facility to visit. The resident's arm remained in the sling. Staff administered acetaminophen (pain reliever) three times on the shift. It was effective within an hour. There was bruising and swelling to the right arm. Staff provided assistance with the resident's activities of daily living. -On 9/15/24 between 7:00 P.M. and 7:00 A.M., the resident remained on IFU. He/She did not complain of pain or distress at the time. At 7:00 P.M., the resident remained on observation, seated in his/her wheelchair. The staff administered acetaminophen three times during the shift. It was effective within an hour. Staff noted no signs of acute distress. The resident did have bruising on the bridge of his/her nose and the right arm. Staff provided assistance with all ADLs; -On 9/16/24 between 7:00 P.M. and 7:00 A.M., the resident remained on IFU/fall with injury. He/She had significant bruising to the entire right arm related to the fracture and a sling in place. At 4:30 P.M., the resident was up in his/her wheelchair propelling him/herself. No complaints of pain or discomfort at the time. His/Her arm was discolored and edematous (abnormally swollen with fluid); -On 9/17/24, no time noted, the resident's arm was extremely swollen and staff noted discoloration from shoulder to hand. His/Her hand was warm to the touch and his/her radial (pulse felt in the wrist) pulse was weak. Staff notified the resident's physician and sent the resident to the ER for evaluation; -On 9/18/24 at 12:20 A.M., the resident returned to the facility and no issues were found with his/her venous Doppler (a non-invasive ultrasound test that uses high frequency sound waves to examine circulations in a person's veins). There were no changes on the x-ray of his/her right hand since the initial x-ray. The resident denied pain. At 6:15 A.M., staff checked on the resident who voiced no pain. At 7:10 A.M., the resident would not get up to use the restroom or attempt to use his/her call light. -On 9/19/24, no time noted, the resident continued to wear an arm sleeve. Staff encouraged him/her to elevate his/her arm. No complaints of pain at the time. Review of the resident's electronic Medication Administration Record (eMAR) dated 9/1/24 through 9/30/24, showed: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-An order dated 9/6/24 for diclofenac sodium (used to reduce pain, swelling and joint stiffness) tablet delay release 75 milligrams (mg). Give one tablet two times a day with food. Documented as administered 9/6 through 9/30/24; -An order dated 6/20/24 for acetaminophen oral tablet 325 mg. Give two tablets every four hours as needed for pain. Two tablets administered on 9/18/24 at 10:00 A.M., 9/28/24 at 9:00 A.M. and 1:00 P.M. and 9/19/24 at 5:00 A.M. and 7:00 P.M. -No documentation of administration for the rest of the month. Review of the orthopedic physician's office visit notes dated 9/19/24, showed: -The resident had been having right upper extremity pain for nine days; -The resident had an injury to the shoulder after a fall; -The resident complained of pain during the day and night and had sleep disturbances; -The resident complained of loss of strength and loss of motion; -At this point they had tried treatment options including activity modification, anti inflammatory medications, acetaminophen and bracing; -The symptoms were not improving with conservative measures; -PROMIS (Patient reported outcomes measurement information system measures health status from the patient's perspective) upper extremity score: 15 (severe dysfunction); -PROMIS pain score 76 (severe); -No current facility administered medication on file prior to visit; -Physical exam: Splint removed; -Skin: Diffuse healing ecchymosis (a widespread bruise, where the discoloration from leaked blood under the skin is spread out over a large area, rather than localized in one spot); -Right upper extremity: Tenderness along the arm. Mobile fracture fragments (pieces of broken bone); -X-ray showed a comminuted shaft fracture (the bone breaks into several pieces) with a long spiral fragment (the bone twists in a corkscrew shape); -Displaced comminuted right proximal humerus fracture (a severe break in the upper part of the arm where the bone shatters into multiple pieces and has shifted out of its normal position); (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Plan: Therapy as tolerated to improve range of motion of wrist and hand. Another x-ray in a week to see if better alignment. Review of the resident's monthly physician's notes, dated 9/19/24, showed: -The chief complaint was a right humerus fracture; -The resident had new or worsening medical problems over the last month; -The resident was feeling tired or poorly; -The resident had a fall in the shower and complained of right arm pain. Sent to the hospital and found to have a right humerus fracture. Ortho consulted and to follow up as outpatient. The resident returned to the nursing home within hours. He/She was going to follow up with ortho today for surgery. His/Her right arm was ace wrapped and his/her hand was swollen; -Resident reported pain and feeling tired or poorly; -He/She reported muscle weakness; -He/She reported lower back pain, left hip joint pain, joint pain in both knees, muscle aches, muscle stiffness and stiffness localized to one or more joints; -He/She reported memory lapses or loss; -He/She reported skin symptoms; -Mild disorientation was observed and judgement was impaired. Review of the resident's progress notes, showed: -On 9/23/24 between 7:00 A.M. and 7:00 P.M., staff notified the resident's physician regarding swelling, redness and warmth in the right arm. A new order was received for doxycycline (used to treat and prevent infections) 100 mg, twice a day by mouth for ten days and lasix (used to treat water retention and swelling) 40 mg one time a day by mouth for ten days. The resident's sling remained intact and staff encouraged him/her to sleep on his/her left side; -On 9/24/24 between 7:00 A.M. and 7:00 P.M., the resident's sling remained in place. His/Her arm and fingers remained edematous; -On 9/29/24 at 8:30 P.M., resident seated in bed watching television, showing no signs and symptoms of pain or distress. Review of the physician's appointment records for the resident on 12/18/24, showed on 9/26/24, the resident's orthopedic appointment with the physician was canceled. Review of the resident's progress notes, showed no documentation of a missed appointment on 9/26/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's eMAR dated 10/1/24 through 10/31/24, showed: Acetaminophen 325 mg. -No documentation of administration 10/1 through 10/31/24. Review of the resident's electronic Treatment Administration Record (eTAR), dated 10/1/24 through 10/31/24 showed: -An order dated 10/2/24 to assess for pain every shift; --On 10/2 through 10/31/24, all areas were left blank for both shifts for pain level. -No documentation of pain level assessed 10/1 through 10/30/24; -An order for diclofenac sodium 75 mg. Give one tablet two times a day for pain. -No documentation of medication administered 10/1 through 10/31/24. Review of the physician's appointment records for the resident on 12/18/24, showed on 10/3/24, the resident did not show up for his/her orthopedic appointment. Review of the resident's progress notes, showed no documentation of missed appointment on 10/3/24. Review of orthopedic physician office visit notes dated 10/10/24, showed: -Chief complaint: Right upper extremity pain; -The resident was unable to follow up since last visit and they had been unable to successfully get medical clearance for surgery until then; -Physical exam: -Right upper extremity: Tenderness along the arm. Mobile fracture fragments. Shoulder and elbow range of motion not attempted due to pain. There was swelling over the elbow forearm and hand and weak elbow flexion and extension (motion of bending and straitening the elbow); -Plan: Resident agreed to proceed with surgery in the form of right humerus, open reduction and internal fixation (surgical procedure to repair broken humerus bone in upper arm. The surgeon makes an incision to realign the bone and uses hardware like screws, plates, rods or pins to hold the bone together); -The surgery would not be scheduled until there was medical clearance. Review of the resident's progress notes, showed on 10/14/24 at 2:50 P.M., the resident's surgeon's office called related to his/her 10/23/24 surgery. They needed surgery clearance. Staff called the resident's physician who stated they would fax the letter on 10/15/24. Review of the resident's physician's appointment records, showed on 10/23/24, the resident was scheduled for surgery. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress notes, showed: -On 10/23/24, the resident was up and ready for his/her appointment with his/her paperwork; -No documentation if surgery occurred or why it did not; -No documentation of notifications to physician or family representative; -No documentation of rescheduling of surgery. Review of the resident's eMAR dated 11/1/24 through 11/30/24, showed: Acetaminophen 325 mg. -No documentation of administration 11/1 through 11/30/24. Review of the resident's eTAR dated 11/1/24 through 11/30/24 showed: -Diclofenac Sodium 75 mg. No documentation of administration 11/1/24 through 11/30/24; -No assessment for pain documented 11/1 through 11/30/24. Review of the resident's monthly physician visit notes dated 11/1/24, showed: -Resident feeling tired or poorly; -Has chronic pain. Seen for follow up. Complained of left hip pain as well; -Seen in wheelchair, wearing a sling on upper right extremity. fell in September suffering a right proximal comminuted fracture and saw ortho. Surgery was canceled and rescheduled. Labs done as pre-operative (pre-op) and they cleared him/her. Review of the physician's appointment records for the resident on 12/18/24, showed on 12/5/24, the resident did not show up for his/her orthopedic appointment. Review of the resident's progress notes showed no documentation of an appointment on 12/5/24 or why it was missed. Review of the resident's eMAR dated 12/1/24 through 12/31/24, showed: Acetaminophen 325 mg. -No documentation of administration 12/1 through 12/18/24. Further review of the resident's eTAR dated 12/1/24 through 12/18/24, showed: -Diclofenac Sodium 75 mg. No documentation of administration 12/1/24 through 12/18/24; -No assessment for pain documented 12/1 through 12/18/24. Review of the resident's monthly physician visit notes dated 12/16/24, showed: (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	-Resident feeling tired or poorly; -Has increased edema right upper extremity and both lower extremities. Was in sling, not using much. Will increase Lasix to two times a day and get labs; -Resident reported lower back pain, left hip joint pain, joint pain in both knees, muscle stiffness and stillness localized to one or more joints; -Not well appearing; -Comminuted right proximal humerus fracture. Now in sling. Cleared for surgery if needed. Review of an email sent by the resident's orthopedic physician's office on 12/18/24, showed the office staff tried to make the appointment with the nursing facility but had not seen the resident since 10/10/24, and no one would call them back. Observation and interview on 12/18/24 at 2:00 P.M., showed the resident sat in a wheelchair in the hallway with a sling on his/her right arm. His/Her head was slumped down, and he/she appeared to be tired. He/She said he/she was not in pain at the moment but had pain when he/she slept and/or moved his/her arm the wrong way. He/She bruised his/her arm in a fall but could not remember the date he/she fell . He/She could report the pain to staff when he/she had it, but it would not do any good. They only gave him/her over the counter medication when he/she complained, and it did not always help. The resident cried out in pain when a staff member attempted to pull his/her right sleeve down to observe the bruising. The brusing was dark purple, greenish and yellowish in color. It started at his/her wrist and extended to his/her shoulder. His/Her arm and hand appeared to be very swollen and red. During an interview on 12/18/24 at 2:10 P.M., Certified Nurse's Aide (CNA) F said the resident expressed pain whenever they had to move his/her arm to assess it. He/She noticed the increased bruising to the resident's right arm that morning when giving the resident a shower and reported it to the nurse. The resident's hands were also extremely swollen. The nurse told him/her it was probably older brusing from the original fall and to just keep an eye on it. The resident did not have this much bruising the week before when he/she gave him/her a shower. The resident complained of pain whenever he/she was transferred or needed help with dressing. If he/she was sitting still in his/her wheelchair, the resident would not complain of pain. During an interview on 12/26/24 at 12:30 P.M., Licensed Practical Nurse (LPN) C said he/she assesses pain by asking the resident if they are in pain and administering pain medications if they are in pain. He/She did not know anything about recording a pain level in the new eMAR. It is a new system, and he/she is still learning how to use it. He/She administered all medications as ordered. He/She did not know the system was not documenting the medication as not administered. He/She does not do formal pain assessments on residents and was not sure who did them or if one was done at all. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265668	A. Building B. Wing	10/21/2024

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Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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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 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/18/24 at 3:00 P.M., the resident's physician office representative said they were aware the resident was scheduled for surgery and missed it on 10/23/24. The physician cleared the resident for surgery and the physician thought the facility was rescheduling it. The physician saw the resident several times after the fall, and he/she did not complain of pain to him those times. That is why he did not order more pain medications. The facility should have been doing pain assessments as soon as the resident returned from the hospital. The facility did not notify the office the resident missed more appointments or the resident continued to have pain. The facility should have notified the physician's office about this. Review of the resident's progress notes, showed on 12/18/24 at 1:30 P.M., staff contacted the hospital to find out the orthopedic surgeon's name. The staff member left a message with the surgeon's scheduler to get surgery rescheduled. At 1:40 P.M., staff contacted the resident's physician to inform him they were trying to reschedule the surgery, however they wanted another X-ray to ensure no additional injury occurred. At 2:20 P.M., the person who set up the schedule from the physician's office called back and indicated he/she would have to contact the orthopedic surgeon to see there was anything else on file. They would reschedule once he/she spoke to the physician and would get back with them no later than 12/21/24. The staff member explained they were requesting an x-ray and would forward it to the physician's office when the results were back. At 2:55 P.M., staff were notified by another resident, the resident had a bruise on his/her right arm. The nurse assessed the arm and noted bruising to the arm, forearm and elbow. The resident had slight swelling to the arm. The resident wore a sling related to his/her shoulder fracture. Staff notified therapy to evaluate the resident for a sling and right arm to ensure the sling was properly positioned as concerns were noted due to swelling and abnormal bruising. The bruising was most likely related to fracture, sling and acute issues involving the right arm. The X-ray company was notified and aware of STAT (immediate) order. Staff were waiting for the X-ray company to arrive. Review of the resident's electronic medical records on 12/18/24, showed no documentation of pain assessments conducted 8/24 through 12/18/24. During an interview on 12/26/24 at 11:15 A.M., Licensed Practical Nurse M said they changed from paper charts to electronic in September 2024. If there is an assessment for pain, LPN M asks the resident if they are in pain and enters in yes or no. Some of the electronic records do not allow him/her to enter a level. If a resident told the LPN he/she was in pain, then he/she would administer as needed medications or notify the physician if the resident did not have an order for pain medication. LPN M would document all of this in the resident's electronic medical record. LPN M does not do the actual pain assessment and did not know who was responsible for this. He/She gave the resident all of his/her ordered medications and did not know why the eMAR was not reflecting this. Review of an email sent by the facility Administrator on 12/26/24, showed the MDS coordinator was responsible for updating the MDSs and care plans. The expectation for updating these records was to obtain any records they could locate. No pain assessments were done between 9/24 and 12/18/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/30/24 at 12:15 P.M. the MDS Coordinator said she was responsible for performing pain assessments on residents quarterly or with a change in condion. This involved reviewing the resident's medication administration records and/or asking the residents their current pain levels. She had not been able to review the medication administration records for a couple of months, but she asked the staff about the resident's pain medication administration and they reported he/she was not having increased pain. She assessed the resident at his/her quarterly MDS update in August and then again on 11/18/24. She did not know why the updated MDS was not showing up in the system. She probably assessed him/her after he/she came back from the hospital with a fractured arm, but he/she was not sure and could not find the documentation. The resident should have been assessed for pain within 14 days after his/her arm was fractured. During an interview on 12/30/24 at 12:30 P.M., the Interim Director of Nursing (DON) said if a resident said they were in pain, staff should ask what level of pain they were experiencing from 1 to 10 and then document that on the eMAR. If the resident had pain medication ordered, it could be administered or if not, the staff member or nurse would notify the resident's physician to get something for the resident's pain. Then the staff would go back an hour later to see if the resident was still in pain and if so, would need to seek out a higher level of pain control. All of this needed to be documented so they could care plan potential pain issues. If pain levels and times were not being documented, then the staff would not know when to administer as needed medications. It would be harder to assess a resident for increased pain without the documentation. Pain assessments were supposed to be done every three months. They would be automatically done if a resident had chronic pain and updated if a resident expressed new pain. The DON could not find a pain assessment in Resident #10's medical file. There should have been one done when the resident came back from the hospital after he/she fractured his/her arm. During an interview on 12/18/24 at 3:15 P.M. and on 12/30/24 at 1:00 P.M., the Administrator said the resident should have been assessed for pain after he/she came back from the hospital with the fractured arm. He/She was not working at the facility when this occurred and did not know the resident was not assessed. If the resident was having pain when staff were providing care, this should have been documented and the physician notified. MO00246748

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on interview and record review, the facility failed to ensure staff maintained documentation of medication as provided on the medication administration record and treatment administration for two months for three of three sampled residents (Residents #11, #12 and #10). The census was 77. Review of the facility's Medication Administration policy, revised on 6/26/24, showed: -Purpose: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice in a manner to prevent contamination or infection. It is the policy of the facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines; -General medication administration process: -Ensure that the six rights of medication administration are followed: 1. Right resident; 2. Right drug; 3. Right dosage; 4. Right route; 5. Right time; 6. Right documentation; -Sign medication administration record (MAR) after administered. For those medications requiring vital signs, record the vital signs onto the MAR; -Correct any discrepancies and report to nurse manager 1. Review of Resident #11's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/16/24, showed: -No behaviors or rejection of care; -Bladder and Bowel: Appliances -Indwelling catheter; -Medications: High risk drug classes use and indication: -Taking anti-psychotic, anti-coagulant (prevents or reduces blood clotting) and anti-depressant; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included: Schizophrenia (a disorder that affects a persons ability to think, feel and behave clearly), abnormal weight loss, adult failure to thrive, gross hematuria (blood in urine), unspecified glaucoma (eye conditions which can cause blindness), hyperlipidemia (high levels of fat particles in the blood), acute cystitis with hematuria (bladder infection), high blood pressure, hereditary and idiopathic neuropathy (inherited nerve damage) chronic kidney disease, insomnia (sleep disorder), muscle weakness, anxiety disorder, chronic embolism and thrombosis of deep vein of right distal lower extremity (a condition where a blood clot forms in a deep vein) and diabetes. Review of the resident's care plan dated 10/16/24, showed: -Problem: Nine plus medications; -Interventions: Administer medications as directed. See physicians order sheets (POS). Monitor for effectiveness, adverse side effects: Increased lethargy, decreased balance, change in appetite or weight, change in sleep and inform physician; -Problem: Anti-coagulation therapy; -Interventions: Administer medications as directed. Monitor for bleeding of nose or gums, bruising, pain or hematuria and notify physician; -Problem: Diabetes; -Interventions: Accu-checks (a blood glucose (sugar) monitoring system) per physician's order. Accu check every Wednesday morning; -Problem: Alteration in urinary function related to supra-pubic catheter (a thin, flexible tube that drains urine from the bladder through a small incision in the lower abdomen) in use; -Interventions: Provide catheter care every shift. Irrigate and change in-dwelling catheter per physician's orders; -Empty catheter drainage bag one time a shift and as needed and document amount of output; -Problem: Psychotropic medication use; -Interventions: Administer anti-depressant and anti-psychotic medications per physician's orders. Monitor for effectiveness/adverse side effects. Review of the resident's POS dated 10/1/24 through 10/31/24, showed: -Tamsulosin HCL oral capsule (cap) 9.4 milligrams (mg). Give one cap by mouth in the morning related to retention of urine. Take at the same time every day after a meal; -Turmeric oral cap, 500 mg. Give one cap by mouth, one time a day for nutritional supplement; -Vitamin C oral tablet (tab) 100 mg. Give one tab by mouth one time a day to promote wound healing; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gabapentin oral cap (used to treat nerve pain), 500 mg. Give one cap by mouth three times a day related to neuropathy; -Senna oral tab 8.6 mg. Give one tab by mouth two times a day for constipation; -Citalopram hydrobromide oral tab (anti-depressant), 40 mg. Give one tab by month one time a day; -Nystatin external cream 100000 unit/grams (gm). Apply to lower abdomen, topically (on the skin) two times a day for skin infection; -Oxybutynin chloride oral tab 5 mg. Give one tab by mouth one time a day related to overactive bladder; -Ferrous Sulfate oral tab 325 mg. Give one tab by mouth one time a day related to iron deficiency; -Eliquis oral tab 2.5 mg. Give one tab two times a day related to chronic embolism and thrombosis; -Atorvastatin calcium oral tab, 80 mg. Give one tab by mouth at bedtime related to hyperlipidemia; -Trazodone HCL oral tab 50 mg. Give 0.5 tab by mouth at bedtime related anxiety disorder; -Melatonin oral tab 3 mg. Give 1 tab at bedtime related to insomnia; -Risperidone oral tab (anti-psychotic) 1 mg. Give one tab at bedtime; -Straight catheter twice daily in A.M., before breakfast and at bedtime if not voiding on own; -Latanoprost Opthlamic solution 0.005%. Instill one drop in both eyes at bedtime related to unspecified glaucoma; -Oxycodone HCL tab 5 mg. Give one tab by mouth every six hours as needed for pain; -Acetaminophen oral tab 325 mg. Give two tabs by mouth every four hours as needed for elevated temperature/pain. Not to exceed 4000 mg in 24 hours; -Supra pubic catheter care with soap and water every shift; -Accu-check every Wednesday. Review of the resident's eMAR dated 10/1/24 through 10/31/24, showed: -Atorvastatin Calcium oral tab: No documentation of administration 10/1 through 10/31/24; -Citalopram Hydrobromide oral tab: No documentation of administration 10/1 through 10/31/24; -Ferrous Sulfate tab: No documentation of administration 10/1 through 10/31/24; -Melatonin oral tab: No documentation of administration 10/1 through 10/31/24; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Oxybutynin tab: No documentation of administration 10/1 through 10/31/24; -Risperidone oral tab: No documentation of administration 10/1 through 10/31/24; -Tamsulosin cap: No documentation of administration 10/1 through 10/31/24; -Oxycodone HCL oral tab: No documentation of administration 10/1 through 10/31/24; -Turmeric oral caps: No documentation of administration 10/1 through 10/31/24; -Anticoagulant medication: Monitor for discolored, black tarry stools, sudden severe headache, diarrhea, muscle/joint pain, lethargy, sudden changes in mental status, shortness of breath, and nosebleeds: X's recorded for 10/1 through 10/3. All boxes left blank after 10/3/24; -Anti-psychotic medication: Monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, dark urine, low blood pressure, yellow skin, lethargy, drooling, tremors, disturbed gait, increased agitation, restlessness or involuntary movement of mouth and tongue: X's recorded for 10/1 through 10/3. All boxes left blank after 10/3/24; -Eliquis oral tab: No documentation of administration 10/1 through 10/31/24; -Nystatin external cream: No documentation of administration 10/1 through 10/31/24; -Gabapentin oral caps: No documentation of administration 10/1 through 10/31/24; -Acetaminophen oral tab: No documentation of administration 10/1 through 10/31/24; -Oxycodone HCL oral tab: No documentation of administration 10/1 through 10/31/24. Review of the resident's electronic Treatment Administration Record (eTAR) dated 10/1/24 through 10/31/24, showed: -Latanoprost Ophthalmic solution: No documentation of administration 10/1 through 10/31/24; -Vitamin C oral tab: No documentation of administration 10/1 through 10/31/24; -Senna oral tablet: No documentation of administration 10/1 through 10/31/24; -No documentation of catheter care noted on eTAR. Review of the resident's 11/1/24 through 11/30/24, POS, showed: -Tamsulosin HCL oral cap 9.4 mg. Give one cap by mouth in the morning; Take at the same time every day after a meal; -Turmeric oral cap 500 mg. Give one cap by mouth, one time a day; -Vitamin C oral cap 100 mg. Give one cap by mouth one time a day; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gabapentin oral cap 500 mg. Give one cap by mouth three times a day; -Senna oral tab 8.6 mg. Give one tab by mouth two times a day; -Citalopram hydrobromide oral tab 40 mg. Give one tab by mouth one time a day; -Nystatin external cream 100000 gm. Apply to lower abdomen, topically two times a day; -Oxybutynin chloride oral tab 5 mg. Give one tab by mouth one time a day; -Ferrous Sulfate oral tab 325 mg. Give one tab by mouth one time a day; -Eliquis oral tab 2.5 mg. Give one tab two times a day; -Atorvastatin calcium oral tablet 80 mg. Give one tablet by mouth; -Trazodone HCL oral tab 50 mg. Give 0.5 tab by mouth at bedtime; -Melatonin oral tab 3 mg. Give 1 tab at bedtime related to insomnia; -Risperidone oral tab 1 mg. Give one tab at bedtime; -Straight catheter twice daily in A.M.; -Latanoprost Ophthalmic solution, 0.005%. Instill one drop in both eyes at bedtime; -Oxycodone HCL tab, 5 mg. Give one tab by mouth every six hours, as needed; -Acetaminophen oral tab 325 mg. Give two tabs by mouth every four hours as needed; -Accucheck. Check and record weekly on Wednesdays; -Supra-pubic catheter. Care with soap and water every shift; -Pain assessment checks every shift. Review of the resident's eMARs, dated 11/1/24 through 11/30/24, showed: -Atorvastatin calcium oral tab: No documentation of administration 11/1 through 11/20, 11/22 through 11/25 and 11/27; -Citalopram tab: No documentation of administration 11/1 through 11/26/24; -Ferrous Sulfate tab: No documentation of administration 11/1 through 11/26/24; -Melatonin tab: No documentation of administration 11/1 through 11/20/24, 11/22 through 11/25 and 11/27; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Oxybutynin tab: No documentation of administration 11/1 through 11/30/24; -Risperidone tab: No documentation of administration 11/1 through 11/18/24, 11/20 through 11/25 and 11/27; -Tamsulosin cap: No documentation of administration 11/1 through 11/18/24 and 11/20 through 11/25/24; -Oxycodone HCL tab: No documentation of administration 11/1 through 11/20/24 and 11/22 through 11/25/24 and 11/27; -Turmeric cap: No documentation of administration 11/1 through 11/25/24; -Anticoagulant medication: Monitor for discolored, black tarry stools, sudden severe headache, diarrhea, muscle/joint pain, lethargy, sudden changes in mental status, shortness of breath, and nosebleeds: No documentation of assessments performed 11/1 through 11/20/24, 11/22, 11/24 , a 9 recorded for 11/21; -Anti-psychotic medication: Monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, dark urine, low blood pressure, yellow skin, lethargy, drooling, tremors, disturbed gait, increased agitation, restlessness or involuntary movement of mouth and tongue: No documentation of assessments performed 11/1 through 11/20/24, 11/21 and 11/22 during the dayshift, 11/22 through 11/24 during the night shift, 11/25 during the dayshift, and 11/27 and 11/30 during the night shift; -Eliquis tab: No documentation of administration 11/1 through 11/25/24; -Nystatin external cream: No documentation of administration 11/1 through 11/18/24, 11/19 on the evening shift, 11/20 through 11/22, 11/23 through 11/25 on the day shift and 11/25; -Gabapentin cap: No documentation of administration 11/1 through 11/30/24; -Acetaminophen tab: No documentation of administration 11/1 through 11/30/24; -Oxycodone HCL tab: No documentation of administration 11/1 through 11/30/24; -No documentation of accuchecks performed 1/1 through 11/18/24. Review of the resident's eTAR dated 11/1/24 through 11/30/24, showed: -Latanoprost Ophthalmic solution: No documentation of administration 11/1 through 11/20/24 and 11/22 through 11/24/24; -Vitamin C oral tab: No documentation of administration 11/1 through 11/20/24 and 11/22 through 11/24/24; -Assess for pain every shift: No documentation of pain assessed 11/1 through 11/20/24, 11/22/24 and 11/22 through 11/24/24 on evening shift; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Senna oral tab: No documentation of administration 11/1 through 11/20/24, 11/22 and 11/24/24 on day shift and 11/21 through 11/24/24 during evening shift; -No documentation of catheter care noted on eTAR. Review of the resident's POS dated 12/1/24 through 12/31/24, showed: -Tamsulosin HCL oral cap 9.4 mg. Give one cap by mouth in the morning; -Turmeric oral cap 500 mg. Give one cap by mouth, one time a day; -Vitamin C oral tab 100 mg. Give one tab by mouth one time a day; -Gabapentin oral cap 500 mg. Give one cap by mouth three times a day; -Senna oral tab 8.6 mg. Give one tab by mouth two times a day; -Citalopram hydrobromide oral tab 40 mg. Give one tab by mouth one time a day; -Nystatin external cream 100000 gm. Apply to lower abdomen, topically two times a day; -Oxybutynin chloride tab 5 mg. Give one tab by mouth one time a day; -Ferrous Sulfate tab 325 mg. Give one tab by mouth one time a day; -Eliquis tab 2.5 mg. Give one tab two times a day; -Atorvastatin calcium tab 80 mg. Give one tab by mouth; -Trazodone HCL tab 50 mg. Give 0.5 tab by mouth; -Melatonin tab 3 mg. Give 1 tab by mouth at bedtime related to insomnia; -Risperidone oral tab 1 mg. Give one tab at bedtime; -Straight catheter twice daily in A.M; -Latanoprost Ophthalmic solution, 0.005%. Instill one drop in both eyes; -Oxycodone HCL tab, 5 mg. Give one tab by mouth every six hours, as needed; -Accucheck. Check and record weekly on Wednesdays; -Supra-pubic catheter. Care with soap and water every shift; -Acetaminophen tab 325 mg. Give two tabs by mouth every four hours as needed. Review of the resident's MAR dated 12/1/24 through 12/31/24, showed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Atorvastatin Calcium tab: No documentation of administration 12/6/24, 12/16 and 12/17/24; -Melatonin tab: No documentation of administration 12/6/24, 12/16 and 12/17/24; -Risperidone tab: No documentation of administration 12/6/24 and 12/16 and 12/17/24; -Trazodone HCL tab: No documentation of administration 12/6/24 and 12/16 and 12/17/24; -Eliquis oral tab: No documentation of administration 12/11/24 on evening shift and 12/17/24 on evening shift; -Nystatin external cream: No documentation of administration 12/6 and 12/7/24 on evening shift and 12/17/24 on evening shift; -Gabapentin cap: No documentation of administration 12/11/24 on afternoon and evening shift and 12/17/24 on evening shift; -Acetaminophen tab: No documentation of administration 12/1 through 12/30/24; -Oxycodone HCL tab: No documentation of administration 12/1 through 12/30/24. Review of the resident's eTAR dated 12/1/24 through 12/30/24, showed: -Latanoprost ophthalmic solution: No documentation of administration 12/9/24, 12/16/24 and 12/17/24; -Vitamin C tab: No documentation of administration 12/6/24 and 12/12/24; -Senna tab: No documentation of administration 12/6/24, and 12/8/24 on the evening shift and on 12/12/24; -Assess for pain every shift: No documentation of assessments performed 12/1 through 12/9/24 on the night shift and 12/12/24 on the day shift; -No documentation of accuchecks performed 12/1 through 12/18/24; -No documentation of catheter care noted on eTARs. 2. Review of Resident #12's quarterly MDS dated [DATE], showed: -No behaviors or rejection of care; -Medications: High risk drug classes use and indication: -Taking anti-psychotic, anti-anxiety and anti-depressant; -Diagnoses included Alzheimer's disease, heart disease, senile degeneration of brain, high blood pressure and vitamin D deficiency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265668	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan dated 8/12/24, showed: -Problem: Nine plus medications; -Interventions: Administer medications as directed/See physician's order sheet; -Problem: Aspirin therapy; -Interventions: Administer medications as directed. Monitor for bleeding of nose or gums, bruising, pain or hematuria and alert physician; -Problem: Potential for pain; -Interventions: Administer as needed pain medications per physician's orders. Administer routine pain medications per physician's orders. Monitor for effectiveness of pain management and alert physician as needed. Pain assessment quarterly/see assessment in chart. -Review of the resident's POS dated 10/1/24 through 10/31/24, showed: -Pain assessment. Check and record every shift; -Alendronate sodium (used to treat osteoporosis) 70 mg , take one tab by mouth weekly on Monday and at least half an hour prior to breakfast; -Aspirin 81 mg tab (used to treat pain). Chew one tablet by mouth daily; -Calcium 250 mg/vitamin D3 125 mg tab (supplement). Take one tab by mouth daily; -Donepezil HCL 10 mg tab (used to treat senile degeneration of brain). Take 1 tab by mouth daily; -Escitalopram 10 mg (used to treat depression). Take one tab by mouth daily; -Ingrezza 40 mg (used to treat tardive dyskinesia). Take 1 cap by moth twice daily; -Lisinopril 2.5 mg (used to treat high blood pressure). Take 1 tablet by mouth daily; -Memantine HCL 1.25 mg (used to treat senile dementia). Take one cap by mouth monthly on the 3rd; -Vitamin D2 (Ergocalciferol) 1.25 mg capsule. Take one cap by mouth on the third Wednesday of each month; -Quetiapine 25 mg tab (used to treat schizophrenia). Half tab by mouth every evening; -Mirtazapine 30 mg tab (used to treat depression). Take one tab by mouth at bedtime; -Acetaminophen 325 mg tab. Take two tab by mouth every four hours as needed for pain; -Hydrocortisone 1% cream (used for dermatitis). Apply topically (to skin) once daily; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lorazepam 0.5 mg tab (used to treat anxiety). Take 1/2 tab by mouth three times daily; -Nizoral 1% shampoo. Apply topically twice weekly. Review of the resident's eMAR, dated 10/1/24 through 10/31/24, showed: -Alendronate Sodium: No documentation of administration 10/7/24, 10/14/24, 10/21/24 and 10/12/24; -Aspirin 81 mg: No documentation of administration 10/1 through 10/31/24; -Calcium-Vitamin D3: No documentation of administration 10/1 through 10/31/24; -Donepezil HCL 10 mg: No documentation of administration 10/1 through 10/31/24; -Ergocalciferol: No documentation of administration 10/1 through 10/31/24; -Citalopram 10 mg (generic for Escitalopram): No documentation of administration 10/1 through 10/31/24; -Ingrezza 40 mg: No documentation of administration 10/1 through 10/31/24; -Lisinopril 2.5 mg: No documentation of administration 10/1 through 10/31/24; -Quetiapine Furmarate 25 mg: No documentation of administration 10/1 through 10/31/24; -Mirtazapine 30 mg: No documentation of administration 10/1 through 10/31/24; -Lorazepam 0.5 mg (should this be 0.5?): No documentation administration 10/1 through 10/31/24; -Acetaminophen 325 mg: No documentation of pain levels or administration of medication 10/1 through 10/31/24. -Anti-anxiety medication: Monitor for drowsiness, slurred speech, dizziness, depressive/impulsive behavior: No documentation of assessments performed 10/1 through 10/31/24; -Antipsychotic medication: Monitor for dry mouth, constipation, blurred vision, orientation/confusion, dark urine, increased agitation or restlessness: No documentation of assessments performed 10/1 through 10/31/24. Review of the resident's eTAR dated 10/1 through 10/31/24, showed Nizoral shampoo: No documentation of administration 10/1 through 10/31/24. -Review of the resident's POS dated 11/1/24 through 11/30/24, showed: -Pain assessment. Check and record every shift; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Alendronate sodium 70 mg , take one tablet by mouth weekly on Monday and at least half an hour prior to breakfast; -Aspirin 81 mg tab. Chew one tablet by mouth daily; -Calcium 250 mg/vitamin D3 125 mg tab. Take one tab by mouth daily; -Donepezil HCL 10 mg tab. Take 1 tab by mouth daily; -Escitalopram 10 mg. Take one tab by mouth daily; -Ingrezza 40 mg. Take 1 cap by mouth twice daily; -Vitamin D2 1.25 mg. Take one cap by mouth month on the 3rd of each month; -Lisinopril 2.5 mg. Take 1 tablet by mouth daily; -Memantine HCL 28 mg. Take one cap by mouth once daily; -Vitamin D2 1.25 mg cap. Take one cap by mouth on the third Wednesday of each month; -Quetiapine 25 mg tab. Take 1/2 tab by mouth every evening; -Mirtazapine 30 mg tab. Take one tab by mouth at bedtime; -Acetaminophen 325 mg tab. Take two tab by mouth every four hours as needed; -Hydrocortisone 1% cream. Apply topically once daily; -Lorazepam 0.5 mg tab. Take 1/2 tab by mouth three times daily; -Nizoral 1% shampoo. Apply topically twice weekly. Review of the resident's eMAR, dated 11/1/24 through 11/30/24, showed: -Alendronate Sodium: No documentation of administration 11/4/24, 11/11/24, 11/18/24 and 11/25/24; -Aspirin 81 mg: No documentation of administration 11/1 through 11/3/24; -Calcium-Vitamin D3: No documentation of administration 11/1 through 11/30/24; -Donepezil HCL 10 mg: No documentation of administration 11/1 through 11/30/24; -Ergocalciferol: No documentation of administration 11/1 through 11/30/24; -Citalopram Oxylate 10 mg: No documentation of administration 11/1 through 11/30/24; -Ingrezza 40 mg: No documentation of administration 11/1 through 11/30/24; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lisinopril 2.5 mg: No documentation of administration 11/1 through 11/30/24; -Quetiapine Furmarate 25 mg: No documentation of administration 11/1 through 11/30/24; -Mirtazapine 30 mg: No documentation of administration 11/1 through 11/30/24; -Lorazepam 0.5 mg: No documentation of administration on 11/1 through 11/18/24 and on 11/19/24 through 11/30/24; -Atorvastatin 40 mg: No documentation of administration 11/1 through 11/20/24 and 11/22 through 11/30/24; -Acetaminophen 325 mg: No documentation of pain levels or administration of medication 11/1 through 11/30/24. -Anti-anxiety medication: Monitor for drowsiness, slurred speech, dizziness, depressive/impulsive behavior: No documentation of assessments performed 11/1 through 11/20/24 and 11/22 through 11/30/24; -Antipsychotic medication: Monitor for dry mouth, constipation, blurred vision, orientation/confusion, dark urine, increased agitation or restlessness: No documentation of assessments performed 11/1 through 11/20/24 and 11/22 through 11/30/24. Review of the resident's eTAR dated 11/1 through 11/30/24, showed Nizoral shampoo: No documentation of administration 11/1 through 11/30/24. Review of the resident's POS dated 12/1 through 12/31/24, showed: -Pain assessment. Check and record every shift; -Alendronate sodium 70 mg, take one tab by mouth weekly on Monday and at least half an hour prior to breakfast; -Aspirin 81 mg tab. Chew one tab by mouth daily; -Calcium 250 mg/vitamin D3 125 mg tab. Take one tab by mouth daily; -Donepezil HCL 10 mg tab. Take 1 tab by mouth daily; -Escitalopram 10 mg. Take one tab by mouth daily; -Ingrezza 40 mg. Take 1 cap by mouth twice daily; -Memantine HCL 1.25 mg. Take one cap by mouth month on the 3rd; -Lisinopril 2.5 mg. Take 1 tab by mouth daily; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Memantine HCL 28 mg. Take one cap by mouth, once daily; -Vitamin D2 1.25 mg cap. Take one cap by mouth on the third Wednesday of each month; -Quetiapine 25 mg tab. Take 1/2 tab by mouth every evening; -Mirtazapine 30 mg tab. Take one tab by mouth at bedtime; -Acetaminophen 325 mg tab. Take two tab by mouth every four hours as needed; -Hydrocortisone 1% cream. Apply topically once daily; -Lorazepam 0.5 mg tab. Take 1/2 tab by mouth three times daily; -Nizoral 1% shampoo. Apply topically twice weekly. Review of the resident's MAR, dated 12/1/24 through 12/18/24, showed: -Alendronate Sodium: No documentation of administration 12/2/24, 12/9/24 and 12/16/24; -Aspirin 81 mg: No documentation of administration 12/1 through 12/18/24; -Calcium-Vitamin D3: No documentation of administration 12/1 through 12/18/24; -Donepezil HCL 10 mg: No documentation of administration 12/1 through 12/18/24; -Ergocalciferol: No documentation of administration 12/1 through 12/18/24; -Citalopram Oxylate 10 mg: No documentation of administration 12/1 through 12/18/24; -Ingrezza 40 mg: No documentation of administration 12/1 through 12/18/24; -Lisinopril 2.5 mg: No documentation of administration 12/1 through 12/18/24; -Quetiapine Furmarate 25 mg: No documentation of administration 12/1 through 12/18/24; -Mirtazapine 30 mg: No documentation of administration 12/1 through 12/18/24; -Lorazepam .05 mg: No documentation of administration 12/1 through 12/18; -Atorvastatin 40 mg: No documentation of administration of medication 12/1 through 12/18/24; -Acetaminophen 325 mg: No documentation of pain levels or administration of medication 12/1 through 12/18/24. -Anti-anxiety medication: Monitor for drowsiness, slurred speech, dizziness, depressive/impulsive behavior: No documentation of assessments performed 12/1 through 12/18/24; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Antipsychotic medication: Monitor for dry mouth, constipation, blurred vision, orientation/confusion, dark urine, increased agitation or restlessness: No documentation of assessments performed 12/1 through 12/18/24; -Assess for pain every shift: No documentation of assessment performed 12/1 through 12/18/24. Review of the resident's TAR dated 12/1 through 12/18/24, showed Nizoral shampoo: No documentation of administration 12/1 through 12/18/24. 3. Review of Resident #10's quarterly MDS dated [DATE], showed: -No behaviors or refusal of care; -Medications: High risk drug classes: Use and indication - Taking anti-psychotics and anti-depressant; -Diagnoses of schizophrenia, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), EPS (a group of side effects that occur due to the use of certain medications), high blood pressure, disorder of thyroid, Gastro-Esophageal reflux disease (GERD - a digestive disease in which stomach acid or bile irritates the food pipe lining), other specified disorders of bone density and structure, muscle weakness and age related osteoporosis (a condition in which the bones become weak and brittle). Review of the resident's care plan dated 9/13/24, showed: -Problem: Nine plus medications; -Interventions: Administer medications as directed. See the POS. Monitor for effectiveness, adverse side effects, lethargy, decreased balance, change in appetite/weight, change in sleep and inform physician; -Problem: Potential for pain; -Interventions: Administer as needed pain medications per physician's orders. Administer routine pain medications per physician's orders. Monitor for effectiveness of pain management and alert physician as needed. Pain assessment quarterly/see assessment in chart; -Problem: Psychotropic medication use; -Interventions: Administer anti-depressant and anti-psychotic medications per physician's orders. Monitor for effectiveness/adverse side effects. Review of the resident's POS dated 10/1 through 10/31/24 showed: -Atorvastatin Calcium 20 mg tab. Take one tab by mouth at bedtime; -Trazodone 50 mg tab. Take 1/2 tab by mouth at bedtime; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Acetaminophen 325 mg tab. Take two tabs by mouth every four hours as needed for pain; -Pantoprazole Sodium Oral tab 20 mg. Give one tab by mouth one time a day related to GERD; -Benztropine Mesylate 0.5 mg. Give two times a month for EPS; -Diclofenac Sodium 75 mg. Give one tablet two times a day for pain; -Fluticasone Propionate Nasal suspension 50 micrograms (mcg). One spray in each nostril two times a day related to allergic rhinitis; -Risperidone oral tab, 2 mg. Give one tab two times a day for schizophrenia and bipolar disorder; -Furosemide (treats fluid retention, Lasix) 40 mg tab. Take one tab by mouth once daily; -Ingressa 40 mg cap. Take one cap by mouth once daily; -Lisinopril 5 mg tab. Take one tab by mouth daily; -Oxybutynin Chloride Expended Release (ER) tab 10 mg. Take one tab by mouth daily; -Oxygen at 2 liters per nasal cannula (a device used to give additional oxygen through the nose) for shortness of breath. Verbally authorize with physician within 24 hours; -Health shakes, three times daily with meals; -Pain assessment, check and record every shift. Review of the resident's eMAR dated 10/1 through 10/31/24, showed: -Atorvastatin Calcium 20 mg: No documentation of administration 10/1 through 10/31/24; -Ingrezza 40 mg cap: No documentation of administration 10/1 through 10/31/24; -Lisinopril 5 mg tab: No documentation of administration 10/1 through 10/31/24; -Oxybutynin tab ER 10 mg: No documentation of administration 10/1 through 10/31/24; -Pantoprazole Sodium tab 20 mg: No documentation of administration 10/1 through 10/31/24; -Trazodone HCL 50 mg: No documentation of administration 10/1 through 10/31/24; -Benztropine Mesylate 0.5 mg: No documentation of administration 10/1 through 10/31/24; -Risperidone oral tab 2 mg: No documentation of administration 10/1 through 10/31/24; -Acetaminophen 325 mg as needed (PRN). No documentation of administration 10/1 through 10/31/24; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Antipsychotic medication: Monitor for dry mouth, constipation, blurred vision, orientation/confusion, dark urine, increased agitation or restlessness: No documentation of assessments performed 10/1 through 10/31/24; -Health shake, three times a day for nutritional supplement: No documentation of administration 10/1 through 10/31/24;. Review of the resident's eTAR dated 10/1 through 10/31/24, showed: -Fluticasone Propionate Nasal 50 mcg: No documentation of administration 10/1 through 10/31/24; -Diclofenac Sodium 75 mg: No documentation of administration 10/1 through 10/31/24; -Change and date oxygen tubing weekly on Sundays, every night shift every Sunday: No documentation tubing was changed and dated 10/6, 10/13, 10/20 or 10/27; -Assess for pain every shift: No documentation of assessments performed 10/2 through 10/31/24. Review of the resident's ePOS dated 11/1/24 through 11/30/24, showed: -Atorvastatin Calcium 20 mg tab: Take one tab by mouth at bedtime; -Trazodone 50 mg tab: Take 1/2 tab by mouth at bedtime; -Acetaminophen 325 mg tab: Take two tabs by mouth every four hours; -Pantoprazole Sodium Oral tab 20 mg: Give one tab by mouth one time a day; -Benztropine Mesylate 0.5 mg: Give two times a month; -Diclofenac Sodium 75 mg: Give one tablet two times a day; -Fluticasone Propionate Nasal suspension 50 mcg, one spray in each nostril two times a day; -Risperidone oral tab 2 mg: Give one tab by mouth, two times a day; -Ingressa 40 mg cap: Take one cap by mouth once daily; -Lisinopril 5 mg tab: Take one tab by mouth daily; -Oxybutynin Chloride ER tab 10 mg: Take one tab by mouth daily; -Antipsychotic medication: Monitor for dry mouth, constipation, blurred vision, orientation/confusion, dark urine, increased agitation or restlessness; -Oxygen at 2 liters per nasal cannula for shortness of breath. Verbally authorize with physician within 24 hours; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Health shakes, three times daily with meals; -Pain assessment, check and record every shift. Review of the resident's eMAR dated 11/1 through 11/30/24, showed: -Atorvastatin Calcium 20 mg: No documentation of administration 11/1 through 11/30/24; -Ingrezza 40 mg cap: No documentation of administration 11/1 through 11/30/24; -Lisinopril 5 mg tab: No documentation of administration 11/1 through 11/30/24; -Oxybutynin tab ER 10 mg: No documentation of administration 11/1 through 11/30/24; -Pantoprazole Sodium tab 20 mg: No documentation of administration 11/1 through 11/30/24; -Trazodone HCL 50 mg: No documentation of administration 11/1 through 11/30/24; -Benztropine Mesylate 0.5 mg: N

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40865 Based on observation, interview and record review, the facility failed to maintain effective pest control by ensuring resident rooms (Resident #4, #5, #3, #6, #7 and #8) were free from bed bugs (small, oval, brown insects that feed on the blood of animals and humans). This failure had the potential to affect all residents. The sample was nine. The census was 79. Review of the facility's Bed Bug Prevention and Management Policy, revised on 5/14/24, showed: -Purpose: Staff will implement measures to prevent, eradicate and contain bed bugs as a part of the facility's overall pest control program; -Policy: The facility shall take a systematic approach to bed bug prevention and management, including monitoring and detection, treatment of affected resident(s), eradication of pests and prevention of recurrence; -Monitoring and detection: -Bed bugs can be hard to find and identify given their small size and their habit of staying hidden; -Bed bugs usually travel on belongings, not people; -Bites on skin are a poor indicator of a bed bug infestation as they can look like bites from other insects, rashes or even hives; -Staff should be aware of the signs of bed bugs: -Rusty or reddish stains on bed sheets, mattresses, furniture, curtains, under loose wall hangings or in electrical receptacles; -Dark spots which are bed bug excrement and may bleed on the fabric like a marker would; -Eggs and eggshells, which are tiny and pale yellow skins that nymphs shed as they grow larger; -Live bed bugs; (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff shall monitor vigilantly when there is an outbreak in the geographical location of the facility; -Since bed bugs usually travel on belongings, pay close attention to the belongings of newly admitted residents and those returning from a stay away from the facility; -Treatment of affected resident(s): -Administer medications or topical treatments as ordered; -Be non-judgmental and offer reassurance as needed; -Eradication of pests: -If a bed bug is found that meets the description of a bed bug, notify pest control company for verification; -Check resident rooms adjacent to the room in which the bug was found. Check at night with a flashlight when bed bugs are most active; -Wash and dry bedding, linens and clothing at high temperatures, and dry with high heat for at least 30 minutes; -Vacuum or steam-clean floors, mattresses and any porous surfaces that cannot be machine-washed. Consider removal of fabric furniture. Implement heat or cold treatments; -Use mattress encasements designed to stop bed bugs; -Combine chemical and non-chemical treatments as recommended by pest control company. The number of treatments will depend on the technique; -Relocate the resident(s) to another room. Close door for (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the duration required by the type of treatment that was implemented (as recommended by pest control company); -Prevention of recurrence: -Keep clutter to a minimum; -Monitor for bed bugs daily at least 30 days as egg to egg life cycle may take four to five weeks. Consider increase in housekeeping/cleaning efforts during this timeframe; -Seal cracks and crevices to remove hiding places; -Follow up on treatment in the recommended timeframe; -Complete incident report of infestation. Maintain documentation of actions taken for treatment, eradication and plans for prevention. 1. Review of the facility's Bed Bug Treatment Records on 11/27/24, showed: -Procedure for bed bugs: -Nursing: Clear all clothing off resident, procure clean clothing, shower resident and only put clean clothing on all shoes, belts, etc. need to stay in room; -Laundry: Take all clothing, belts and put in dryer for one hour heat; -Housekeeping: Clean room thoroughly, check room every day for one week and more accordingly; -Maintenance: Spray whole room, if bugs on mattress, throw away and replace with the new mattress after spray on new mattress. Spray all baseboards, window sills, pictures, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appliances, bed rails and bed piping. Put powder on whole room perimeter, around light sockets, switches, etc. Repeat step four weekly for four weeks; -Forms dated 9/12/24 and 9/18/24, showed: -Rooms 136, 200, 201, 203, 205, 207, 209, 211, 212, 234 and 237, sprayed and powder applied; -Form dated 9/19/24, showed: -Rooms 136, 200, 201, 203, 205, 206, 209, 211, 213, 234 and 237, sprayed and powder applied; -Form dated 9/26/24, showed: -Rooms 136, 200, 201, 203, 205, 206, 207, 211 and 212, sprayed and powder applied; -Form dated 10/1/24, showed: -Rooms 136, 200, 203, 205, 206, 212 and 213, sprayed and powder applied; -Form dated 10/10/24, showed: -Rooms 200, 203, 205, 206, 211, 212, 213, 503, 504, 508 and kitchen hall sprayed and powder applied; -Form dated 10/17/24, showed: -Rooms 203, 205, 206, 211, 212, 503, 504, 508 and kitchen hall sprayed and powder applied; -Form dated 10/21/24, showed: -Rooms 139, 205, 206, 209, 211 and 407, sprayed; -Form dated 10/24/24, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265668	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Health Care Center	5000 South Broadway Saint Louis, MO 63111

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Rooms 205, 206, 209, 210, 211, 213, 503, 504, 508 and kitchen hall, sprayed; -Form dated 10/31/24, showed: -Rooms 139, 203, 205, 206, 209, 211, 212, 503, 504 and 508 sprayed; -Forms dated 11/7/24 and 11/14/24, showed: -Rooms 139, 205, 206, 209, 211 and 407, sprayed. Review of a pest control company estimate dated 11/2/24, showed: -Bed bug chemical treatment for 105 beds and setting traps for the bed bugs would cost $7,875.00; -The facility would supply the traps. During an interview on 11/27/24 at 9:10 A.M., the Maintenance Director said he uses Diatomaceous Earth (causes insects to dry out and die) powder and a combination bed bug spray (targets bed bugs at all different stages), to control bed bugs because they are safe for the residents. When a resident or staff member reports bed bugs, staff remove the resident from that room, launder all his/her clothes and he treats the room with powder and spray chemicals. He does not treat all of the rooms in the adjacent area unless there has been a report of bed bugs in those rooms. The mattresses are treated but not removed because they are encased in plastic covers unless the mattress shows signs of infestation, then it is removed. The resident's clothing is bagged up in plastic and sent to the laundry to keep it separate from other residents' clothes. They usually move the residents out of the room for 24 hours while it is being treated. Review of the 10/24, Environmental Protection Agency's (EPA) guidelines for treating bed bugs, showed pesticides are often an important part of a control strategy, but they must be used properly for the treatment to work. There can be many reasons for failure of a pesticide treatment to completely control the bed bugs, including: -Not finding all the bed bugs. -Inadequately preparing area (failure to remove clutter, seal cracks and crevices, etc.). -Overlooking treatment of any of the known resting areas (bed bugs may rest or hide in hampers, bed frames, even furniture). Failing to treat nearby areas where bed bugs may have migrated (adjacent rooms or other apartments in multi-dwelling housing). -Disregarding recommended label rates (applying pesticides at too low a rate may not kill bugs and may speed up development of resistance to that chemical). (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Not following up on treatment in an appropriate timeframe (many pesticides will not kill eggs, so treatment must be repeated after the eggs hatch, or the infestation will not be controlled). -Not allowing enough time for a pesticide to work (some pesticides, such as drying agents or growth regulators, may be effective but take some time to kill the population). -Bed bugs becoming resistant to a specific type of pesticide. As insects, such as bed bugs, are exposed to a pesticide over time, the most susceptible ones are killed first, leaving only the less susceptible ones to breed. This can result in a rapid decline in relative effectiveness of the pesticide. 2. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/15/24, showed he/she was able to understand others and be understood. During an interview on 11/27/24 at 9:25 A.M., Resident #4 said he/she saw bed bugs in the facility. It was frustrating because the staff would spray the rooms and change the sheets and then when the new linen was sent up from the laundry, it would have live bed bugs in it. The bed bugs were accumulating in the plastic covers on the mattresses. 3. Review of Resident #5's annual MDS, dated [DATE] , showed he/she was able to understand others and be understood. During an interview on 11/27/24 at 9:45 A.M., Resident #5 said the staff treated his/her room several times, but he/she could still see the bed bugs crawling up his/her walls sometimes. 4. Observation of resident room [ROOM NUMBER] on 11/27/24 at 9:50 A.M., showed two live bed bugs in the seam of the mattress cover. 5. Review of Resident #3's quarterly MDS, dated [DATE], showed he/she was able to understand others and be understood. Observation of Resident #3's room on 11/27/24 at 9:55 A.M., showed large amounts of a powder substance on the floor in front of the bed, on the bottom of the bedside table and along the wall. During an interview on 11/27/24 at 10:00 A.M., the resident said he/she sees bed bugs every day. The bugs hide during the day and come out at night and bite him/her. He/She gets blood all over his/her sheets where they have bitten him/her. He/She pointed to a reddish stain on the wall and said that was where he/she had killed a bed bug the prior night. The powder along the floor is where the maintenance staff treated his/her room two weeks ago. They had not treated his/her room since that time. He/She tried to keep his/her room clean and showers every day to try and prevent the bed bugs, however, he/she had seen them and picked them off other residents when he/she helped them to the dining room. 6. Review of Resident #6's quarterly MDS, dated [DATE], showed he/she was able to understand others and be understood. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #6's room on 11/27/24 at 10:05 A.M., showed a live bed bug in the folded linen on the bed. During an interview on 11/27/24 at 10:07 A.M., the resident said he/she sees bed bugs in his/her room all the time. He/She sees them crawling on the floor, the walls and in his/her bed linen. He/She gets bitten every night. He/She has had to pick them out of his/her navel (belly button). He/She complains to staff about it all of the time. 7. Review of Resident #7's quarterly MDS, dated [DATE], showed he/she was able to understand others and be understood. Observation of Resident #7's room on 11/27/24 at 10:15 A.M., showed the room cluttered with bags of clothes and boxes of personal items. There was a powdery substance on the floor in front of the bed, around the bed rails and along the wall. During an interview on 11/27/24 at 10:18 A.M., the resident said he/she had bed bugs in his/her room since he/she moved in. The maintenance staff sprayed his/her room six or seven times, but whatever they were using was not killing the bugs. A bed bug bit him/her in the neck last night. The staff changed his/her mattress out, but the bed bugs were coming from everywhere. They offered to change his/her room, but all of the rooms are infected with bed bugs. There was an infestation in the whole building. 8. During an interview on 11/27/24 at 10:20 A.M., Housekeeper I said he/she saw bed bugs in the facility. Maintenance staff were trying to treat them, but they were still everywhere. 9. During an interview on 11/27/24 at 10:25 A.M., Certified Nurse's Aide (CNA) G said there was a problem with bed bugs in the facility. Resident #8's room had to be treated a couple of days ago because he/she had them all over his/her body. They were crawling all over the resident's mattress and in his/her hair. It was terrible. They did not even move the resident out of the room. 10. Review of Resident #8's annual MDS, dated [DATE], showed he/she was able to understand others and be understood. During an interview on 11/27/24 at 10:30 A.M., Resident #8 said he/she complained to staff several times about the bed bugs biting him/her. They were everywhere. He/she saw them on his/her wall earlier that morning. They only started spraying his/her room yesterday. Observation of the laundry room on 11/27/24 at 11:00 A.M., showed a plastic bag of clothes on the floor by the washer with Resident #8's name, with a note attached that the clothing in the bag contained bed bugs. 11. During an interview on 11/27/24 at 10:35 A.M., CNA H said he/she saw bed bugs on residents, their beds and in their linen. They were supposed to shower the resident, put their laundry in a plastic bag with their name and notify maintenance so they could treat the rooms. He/She did not think the treatment was working because the bed bugs were everywhere. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. During an interview on 11/27/24 at 11:50 A.M., an unidentified resident said he/she did not have bed bugs, but other residents had them. One of the nurses told him/her the staff could no longer hug them because they did not want to take bed bugs home. It hurt because he/she liked hugging the staff and did not feel like it was his/her fault the facility had bed bugs. 13. During an interview on 11/27/24 at 11:20 A.M., the Social Worker said he/she had not seen live bed bugs, but the residents told him/her about them sometimes. Whenever a resident told him/her there were bed bugs in their room, he/she would notify the Maintenance Director so he could treat the room. 14. During an interview on 11/27/24 at 11:30 A.M., Licensed Practical Nurse C said he/she saw live bed bugs, and some of the residents complained about them. They were supposed to shower the resident if he/she had bed bugs in their room and wash their hair. Maintenance staff would spray their room. Then the housekeepers cleaned the rooms and the laundry washed their clothes and linen. Some of the residents complained about being bitten, but he/she performed skin assessments on the residents every week and had not seen any evidence of bites. 15. During interviews on 11/27/24 at 9:10 A.M. and 1:00 P.M., the Administrator said she knew they had bed bugs, but they were treating them and it was working. The corporation who owned the facility got bids for bed bug removal from some pest control companies but had not hired anyone yet because they thought the problem was getting better. She did not know the residents were still complaining about bed bugs. MO00244663 MO00245600