

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 07/03/2025
NAME OF PROVIDER OR SUPPLIER Carrie Elligson Gietner Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications on the 200 hallway, were stored properly for multiple residents, including two sampled (Residents #1 and #2), which had the potential to cause harm to all residents. The sample was five. The census was 87. Review of the facility's medication storage policy, dated 5/18/24, showed:-Policy: All drugs and biologicals will be stored in locked compartments, cabinets, drawers, refrigerators, under proper temperature control. Narcotics and controlled substance medications are stored under double lock and key;-Any discrepancies which cannot be resolved must be reported immediately as follows: Notify the Director of Nursing (DON), charge nurse, and the pharmacy. Complete an incident report detailing the discrepancy, steps taken to resolve it, and names of all licensed staff working when the discrepancy was noted. Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies. 1. Observation on 7/3/25, at 7:25 A.M., of the nurse's station on the second floor, showed:-The nurse's station was located in an open room with no doors. The nurse's station was open and accessible for anyone to walk behind it;-An open box, positioned on the ground behind the nurse's station, in front of a medication cart. The box contained 45 cards of medication;-A trash bag on the ground behind the nurse's station contained finished medication cards that needed to be disposed of, along with one of the medication cards still containing medications;-An open box, on the ground contained finished medication cards that needed to be disposed of;-An open box, positioned under the desk behind the nurse's station. The box contained over 45 cards of medication;-A open box, positioned under the desk behind the nurse's station next to the previous box. The box contained over 45 cards of medication. Observation on 7/3/25 at 8:43 A.M. and 10:48 A.M., of the nurse's station on the second floor, showed:-An open box, positioned on the ground behind the nurse's station, under the desk. The box contained 45 cards of medication;-A trash bag on the ground behind the nurse's station contained finished medication cards that needed to be disposed of. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/9/25, showed:-Moderate cognitive impairment;-Diagnoses included acute kidney failure, heart failure, and schizophrenia (mental illness that affects the way a person thinks, feels and behaves). Observation on 7/3/25 at 7:27 A.M., of the nurse's station on the second floor showed the following under the desk:-A medication card labeled with the resident's name. The medication card contained 28 hydrochlorothiazide (high blood pressure medication) 12.5 milligram (mg) capsules;-A medication card labeled with the resident's name. The medication card contained 14 Farxiga (diabetic medication) 10 mg tablets;-A medication card labeled with the resident's name. The medication card contained 28 Amlodipine (high blood pressure medication) tablets. 3. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-Diagnoses included chronic kidney disease and heart failure. Observation on 7/3/25 at 7:28 A.M., of the nurse's station on the second floor showed the following under the desk:-A medication card labeled with the resident's name. The medication card contained 28 hydroxyzine (antihistamine) 10 mg tablets. 4. During an interview on 7/3/25 at 7:20 A.M., Certified Medication Technician (CMT) A said the pharmacy comes around once a month to deliver medication to the facility. The medication is delivered in boxes and then placed behind the nurse's stations for staff to put the medications away in storage. The medication is not stored in a timely manner and normally sits behind the nurse's station where anyone has access to it. The facility policy should store medication as soon as it is delivered. 5. During an interview on 7/3/25 at 9:08 A.M., CMT B said CMTs and nurses are responsible for putting away medications in the proper storage areas when it is delivered. If medication cannot be put away right away, it should be locked in the storage room. Medication should never be left unattended because residents could get into it. 6. During an interview on 7/3/25 at 11:51 A.M., the Regional Nurse Advisor said he would expect boxes of medication to be put away in the proper storage locations. Nurses are responsible for checking in medication and putting them away. The medication boxes observed behind the nurse's station desk were delivered on 6/28/25 and should have been stored properly on the day it was delivered. Residents should never be behind the nurse's station for safety purposes. 7. During an interview at 12:45 P.M., the Administrator and DON said they would expect nursing staff to follow the medication storage policy. They would expect medication to be put away as soon as it is delivered or stored in the locked medication storage room until it can be placed on the medication carts.MO00256390</p>		