

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 09/22/2025
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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to meet professional standards when staff failed to make an appointment and follow up with a urologist (specializes in the urinary and reproductive systems) as requested by the urologist for one resident. (Resident #4). The census was 86. Review of the facility's Transcription of Orders/Following Physician's Orders Policy, dated 5/18/24, showed the following:-Purpose: The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders;-Procedure:-A. Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section; -B. Clarification of Physician's Orders will be obtained if the order is either unclear or the nurse is uncomfortable in implementation of the Physician's Orders. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/10/25, showed the following:-Moderate cognitive impairment;-Required partial to moderate assistance with activities of daily living;-Diagnoses of high blood pressure, anxiety and depression. Review of the resident's nurse's note, dated 7/28/25 at 5:06 P.M., showed the nurse received a call from the urologist. He/She said the resident has diagnosis of prostate cancer (abnormal, uncontrollable growth of cells in the prostate gland, a part of the male reproductive system) and needs treatment. He/She said the resident has a follow up appointment in September but wants the resident to have an urgent appointment this week. The doctor has two offices, one for Tuesday appointment before noon. And a second for Friday appointment in morning. A transportation sheet made out. One copy was placed under social services door and a copy placed in transportation book. Review of the resident's medical record, showed no documentation regarding scheduling an appointment or the resident going to an appointment. During an interview on 9/22/25 at 12:47 P.M., Certified Nurse Aide (CNA) A said he/she escorted the resident to a doctor's appointment on 8/1/25. CNA A said they arrived at the doctor's office, they were turned away for not having an actual appointment on that day. CNA A said he/she and the resident came back to the facility and he/she made the charge nurse (unknown person) aware the resident returned without being seen. CNA A said he/she did not know if there was any follow up at that time. During an interview on 9/25/25 at 9:21 A.M., Licensed Practical Nurse (LPN) B said the resident came back to the facility and went to the previous Administrator's office. LPN B was told the DON and Administrator would handle the situation. LPN B said he/she did not know if another appointment was made for the resident. During an interview on 9/8/25 at 1:40 P.M., the resident said he/she had prostate surgery about six months ago. The resident said he/she did not know if he/she had an appointment with a urologist. He/She did not remember going to an appointment. The resident said he/she would probably find out from the Administrator. Review of the resident's medical record, showed no documentation of a scheduled appointment for the resident to see the urologist. During an interview on 9/22/25 at 10:23 A.M., Nurse C said he/she works with the urologist. When the urologist called the facility and made the recommendation for the resident to be seen immediately, the facility should have called and scheduled an appointment for the resident to be seen as soon as possible. Nurse C said without an appointment, the resident will not be seen. The resident was seen on 9/12/25. During an interview on 9/8/25 at 2:30 P.M., the DON said he/she expected the facility's policy to be followed. The Charge Nurse is to make the appointment and chart the date and time in the resident's medical record. The Charge Nurse should notify Social Services to set up the transportation. The Administrator was present at that time and agreed with the DON. 2609855</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) seven days a week. This had the potential to affect all residents of the facility. The sample was five. The census was 86. Review of the facility's Sufficient Staffing Policy, dated February 2023, showed the following:-Purpose: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.-Policy: -The facility is required to provide licensed nursing staff 24 hours a day, 7 days a week;- Except when waived, the facility must use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Review of the facility's daily staffing sheets showed the following:-8/20 through 8/22/25, no RN scheduled;-8/25 through 8/31/25, no RN scheduled;-9/1 through 9/5/25, no RN scheduled. During an interview on 9/8/25 at 12:42 P.M., the Director of Nursing (DON) said the facility currently only has two RNs in the building. The DON said he/she has been working as an RN on the floor but did not know he/she could not be the DON and the RN on the floor at the same time. The Administrator was present at the time and agreed with the DON. 16113302606159</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure recipes were followed while preparing pureed meals for one of one observed mealtime preparation. The census was 86. Observation on 9/22/25 at 11:05 A.M. of the kitchen, showed [NAME] D took one breaded chicken breast, placed it in a blender and added approximately one tablespoon of water and blended for approximately 45 seconds. Observation after blending, the breaded chicken breast appeared to be of ground meat consistency and not smooth. [NAME] D portioned the mixture into tin pans and placed it on the steamtable. Review of the facility's Pureed Breaded Chicken Breast recipe, dated 2025, showed the following:-One Serving: One breaded chicken breast, four tablespoons and two teaspoons of water and one fourth teaspoon of chicken base;-Combine chicken base and water to make chicken broth. Place prepared breaded chicken breasts in a sanitized food processor. Add broth and blend until smooth. During an interview on 9/22/25 at 11:15 A.M., [NAME] D said he/she should have followed the recipe for the pureed breaded chicken breast. [NAME] D said he/she looked at the recipe and thought he/she was following the recipe. Observation on 9/22/25 at 11:17 A.M., showed [NAME] D took one and one half four-ounce (oz) scoop of mixed vegetables and placed in a blender and blended for approximately 45 seconds. Observation after blending, showed the mixed vegetables were smooth with small lumps of vegetables. During an interview on 9/22/25 at 2:04 P.M., the Dietary Manager (DM) said he/she did not have a recipe for pureed mixed vegetables. They are just pureed until smooth. They never had a recipe for mixed vegetables. The DM expected the cooks to follow the recipes as written to ensure the proper nutrition for the food. The DM did not know why the cooks did not follow the recipes. The Administrator was present and said he/she agreed with the DM. 2619550</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review, the facility failed to keep the kitchen walls clean and floors free of grease, dirt and grime for one of one day of observation. The census was 86. Review of the facility's Dietary Cleaning Duties, undated, showed the following: -Morning Crew: Wipe down all stainless surfaces, clean ovens and stove top, mop kitchen and dining room; -Evening Crew: Wipe down all stainless surfaces, clean ovens and stove top, mop kitchen and dining room; All employees must clock out with work completed at designated time. The cook on duty is responsible for checking that above duties are completed before they clock out. Manager is to assure this process is carried out. Observation on 9/22/25 of the kitchen, showed the following: -9:00 A.M., the floor under the refrigerator and along the back wall had dirt built up and grime; -9:02 A.M., the floor under the stove and fryer had built up grease and grime and the walls next to the fryer had built up grease and grime; -9:04 A.M., the floor under the coffee station had built up dirt and grime; -11:04 A.M., the walls behind and alongside the three sinks had built up grease and grime. During an interview on 9/22/25 at 2:15 P.M., the Dietary Manager (DM) said the cooks and the servers should deep clean the kitchen each day. The DM said the dietary staff are not allowed to have overtime, so the kitchen has not been cleaned properly. The DM said his department did not have labor hours for deep cleaning. During an interview on 9/22/25 at 2:20 P.M., the Administrator said she was aware of the concerns with the cleanliness of the kitchen. 2606159</p>		