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	05/21/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure resident rooms (Resident #2), resident common area meeting spaces, and resident belongings were kept in a clean, safe, and homelike manner. Concerns were noted with shower rooms on the 300, 500 and 100 hall, resident phone rooms, and with the sunrooms at the ends of resident halls. The sample size was 20. The census was 97.Review of the facility's Safe and Homelike Environment policy, revised 6/5/24, showed:-In accordance with the residence rights, the facility will provide a safe, clean, comfortable, and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk;-A homelike environment is one that D emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a home like environment. A determination of homelike should include the residence opinion of the living environment;-The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting;-Housekeeping and maintenance services will be provided as necessary to maintain a sanitary and comfortable environment;-The facility will provide and maintain bed and bath linens that are clean and in good condition. Review of the facility's Housekeeping - Deep Cleaning Policy, revised 6/29/23-All areas should be monitored on a daily basis and all resident living areas and non living areas should be clean and odor free;-Daily cleaning: Pick up all trash and put into trash can and empty, dust mop or sweep floor, and clean shower rooms inside the shower, around the shower, and the baseboards in the room;-Bathroom floors will be swept and mopped and any dirt, grime, or stains will be hand scrubbed with stiff brush or other equipment suitable for removing surface dirt from entire floor. If the stain is not removable then housekeeper will notify maintenance department with a maintenance request form. 1. Review of Resident # 2's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/11/26, showed:-Cognitively intact;-No rejection in care;-Requires partial to moderate assistance with personal hygiene and bathing;-Diagnosis include, schizophrenia (a mental condition that distorts reality), infection of intravertebral disc (a part of the back), malnutrition (poor nutrition), and viral hepatitis (inflammation of the liver caused by a virus). Observation on 5/17/26 at 10:10 A.M., 5/18/26 at 9:05 A.M., and 5/19/26 at 8:45 A.M., showed the resident lay in bed. The white fitted bed sheet had stains and dark discoloration. Multiple bottles of empty soda bottles, crumbs of food, food wrappers, and cups of undigested food in clear cups were on the resident's floor next to his/her bed. Multiple personal items were in the residents' room and closet. During an interview on 5/18/26 at 9:05 A.M., the resident said he/she wasn't sure if his/her room was cleaned every day. The resident said he/she was messy and tried to pick things up him/herself but really couldn't, due to pain. The resident said he/she was having difficulty swallowing and that was why he/she spit food and saliva in the cups 2. Observation on 5/17/26 at 8:43 A.M. of the 300 hall Tub Washroom, showed two large industrial trash cans filled with waste lined up next to the tub. Broken baseboard pieces and broken tiles were observed behind the washroom's toilet. Observation on 5/17/26 at 9:07 A.M. of the shower (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room on the 500 hall, showed three large industrial trash cans blocking access to the sink and cabinets. A soiled blue sock was observed in the bathtub. Observation on 5/18/26 at 9:27 A.M. of the shower room on the 500 hall, showed three large industrial trash cans blocking access to the sink and cabinets. A soiled blue sock was observed in the bathtub. Observation of the 100 hallway shower room, showed:-On Observation on 5/19/26 at 9:02 A.M., the room had a mildew-like smell. Dirty towels were on the ground under the bench and on top of the shower bench. A wet towel was on the ground. Hair was on the ground and on the shower wall. A used white washcloth was on the ground in the right corner of the room; -On 5/20/26 at 6:59 A.M., the room had a mildew-like smell. Hair was on the floor and the shower wall. A used washcloth was on ground in the right corner of room; -On 5/21/26 at 6:43 A.M., wet towels were on the ground in front of the shower bench. Hair was on the ground and on the shower bench. A used white washcloth was on the floor in the right corner of the room. During an interview on 5/17/26 at 10:10 A.M., Resident #2 said he/she didn't take showers because the shower room was so filthy. The facility did not provide any type of shoes to wear in the shower, and he/she did not want to put his/her bare feet directly on the shower floor. 3. Observation 5/17/26 9:28 A.M. of the 300 hall resident Phone Room, showed a small room with a sitting table and chairs with a phone available for residents to use. The room's floor had a dark, sticky stain in the center of the room and pieces of plastic trash were observed in the corner of the room near the doorway.Observation 5/18/26 9:16 A.M. of the 300 hall resident Phone Room, showed a small room with a sitting table and chairs with a phone available for residents to use. The room's floor had a dark, sticky stain in the center of the room and pieces of plastic trash were observed in the corner of the room near the doorway. 4. Observation on 5/17/26 at 8:42 A.M. of the sunroom at the end of the 300 East resident's hall, showed an empty wood pallet propped up against the [NAME] wall of the sunroom. Observation on 5/19/26 at 9:00 A.M., of the 100 hallway sun room, showed:-A large dead cockroach was on ground in the corner of the room;-Trash debris was on ground in various areas;-Grey cigarette ash was on the ground behind the desk;-Food wrappers were on the desk. The desk was visibly dusty. Observation on 5/21/26 at 6:45 A.M., showed:-Food wrappers were on the desk. The desk was visibly dusty. 5. During an interview on 5/17/26 at approximately 9:00 A.M., Housekeeper H said the hall shower rooms, common areas, and resident rooms were cleaned daily and as needed. During an interview on 5/21/26 at 11:20 A.M., Certified Nursing Assistant (CNA) L said the nursing staff changed sheets daily and as needed and the housekeeping staff cleaned the resident rooms and swept the floors once daily. During an interview on 5/21/26 at 8:54 A.M., Licensed Practical Nurse (LPN) A said Certified Nursing Assistants (CNA) were responsible for ensuring dirty linen was taken out of the shower rooms. He/She said housekeeping was responsible for cleaning the shower rooms. He/She said the shower rooms were cleaned once a day and as needed. During an interview on 5/21/26 at approximately 10:00A.M., the Housekeeping Supervisor said resident rooms and the shower rooms on resident halls were expected to be cleaned daily and as needed. During an interview on 5/21/26 at 2:22P.M., the Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse Consultant said she would expect all shower rooms and resident rooms to be cleaned daily and as needed. The Administrator said she would expect facility staff to complete the inventory list on admission and when new items were brought in for a resident. She would expect all rooms to be cleaned daily and sheets to be changed when visibly soiled.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received appropriate activities of daily living (ADL, daily care) care to meet the needs of residents by not assisting three residents with their showers (Resident # 35, Resident #25 and Resident #2) and provide foot care for one resident (Resident #25). The facility also failed to assist one resident during mealtimes (Resident #55). The sample size was 20. The census was 97. Review of the facility's ADL policy, dated 5/18/24, showed:-Purpose: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable;-Cares and services will be provided for the following ADLs;-Bathing, dressing, grooming and oral care;-Transfer and ambulation;-Toileting;-Eating to include meals and snacks; and systems;-Policy: The facility will provide a maintenance and restorative program to assist the residents in achieving and maintaining the highest practicable outcome base on the comprehensive assessment.-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's Podiatry Services policy, last revised on 5/14/24, showed:-Purpose: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health;-Policy:-Foot care that is provided in the facility, such as toenail clipping for residents without complicating disease processes, should be provided by staff who have received education and training to provide this service;-Residents requiring foot care who have complicating disease processes will be referred to qualified professionals such as a podiatrist (foot doctor). 1. Review of Resident #35's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) dated 2/10/26, showed:-Diagnoses included cerebrovascular accident (CVA, stroke), paraplegia, malnutrition, depression, schizophrenia, and asthma;-Cognitively intact;-Impairment on both sides to upper and lower extremity;-Uses wheelchair;-Substantial/maximal assistance for eating;-Dependent with oral hygiene, toileting, shower/bathe self, upper and lower body dressing, and personal hygiene. Review of the resident's care plan, in use during survey, showed:-Problem: Resident has an Activity of Daily Living (ADL) self-care performance and mobility deficit related to spinal injury paraplegia, poor coordination, obesity, weakness, and neurological impairment requiring maximum assistance with ADLs;-Interventions:--Monitor for fatigue and poor coordination;--Provide max assist with ADLs, transfers, mobility, and hygiene;--Two staff members for ADL care;--Bathing/showering: Resident is totally dependent on 1-2 staff to complete this task;--Bed mobility: The resident is totally dependent on staff for repositioning and turning in bed;--Personal hygiene/oral care: The resident is totally dependent on one staff for personal hygiene and oral care;--Encourage the resident to discuss feelings about self-care deficit;--Encourage the resident to use bell to call for assistance;--Monitor/document/report as needed (PRN) any changes, any potential for improvement, reasons for self-care, deficit, expected course, decline in function; -Problem: Resident's family member came into facility to discuss resident's care;-Interventions:--Staff will offer daily get ups to resident;--Showers will continue to be offered 2x a week. Review of the resident's shower sheets, May 2026, showed:-On 5/2/26, a bed bath and signed by Certified Nursing Aide (CNA) and charge nurse;-On 5/6/26, a shower was documented and signed by CNA and charge nurse;-On 5/9/26, a bed bath or shower was not documented. It was signed by CNA and charge nurse;-On 5/13/26, a bed bath or shower was not documented. It was signed by the charge nurse;-On 5/16/26, no staff signature or other written documentation. During an observation and interview on 5/20/26 at 2:38 P.M., the resident said showers were not frequent, it was whenever staff wanted to take him/her there. Cleanliness was a part of nursing too. He/She asked for a shower in the past and was told no due to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reasons such as staffing or broken or no shower bed. Staff changed his/her brief, but that is it. When he/she received a bed bath, it was not sufficient because they used wipes on his/her back. He/She asked staff not to do that. They called it a bed bath, but it was only a wet wipe without any water. If he/she received a shower, staff did not moisturize his/her skin. His/her shower days were Wednesday and Saturday and confirmed today was his/her shower day. His/Her scalp was very itchy, and his/her hair had not been washed. He/She did not remember the last shower, but it was the end of last month. His/her scratched his/her scalp a lot. The resident never refused a shower. Staff documented he/she refused, but no one talked to him/her about refusal. The resident said when he/she was at a former facility, he/she signed the shower sheet if they refused. The resident believed staff should do the same here. The resident's hair appeared matted, covered with a large amount of dandruff, presenting as whitish flakes throughout his/her hair. During an interview on 5/20/26 at 3:38 P.M., Licensed Practical Nurse (LPN) I said sometimes the resident refused to get out of bed. For example, he/she told staff he/she would not get out of bed if certain people were out there or in the hall. He/She was not known to refuse showers. During an interview on 5/20/26 at 3:41 P.M., CNA J said the resident did not have any refusals for showers or getting out of bed. Sometimes, in a sarcastic way, he/she would say, I did not know I could get out of bed. During an interview on 5/21/26 at 9:52 A.M., the Administrator said the resident had not received a shower since 5/6/26. She was uncertain if the resident wanted it and did not hinder the shower. She would inform nursing so the resident could receive a shower. During an interview on 5/21/26 at 10:30 A.M., CNA K said he/she used two gray buckets for bed baths. One bucket has hot water and the other was for the soap. They used soap and wash cloths, depending on the part of the body. If a resident requested wipes, he/she would use them. Otherwise, he/she used a washcloth. 2. Review of Resident #25's, quarterly MDS, dated [DATE], showed:-Moderate cognitive impairment;-No rejection of care;-Uses a walker and wheelchair;-Partial to moderate assistance with personal hygiene, bathing, toilet hygiene, putting on and taking off footwear;-Requires supervision or touching assistance from staff for lower body dressing;-Diagnosis includes chronic (long term) lung disease, high blood pressure, heart failure, morbid obesity and difficulty walking. Review of the resident's care plan, in use during the time of the investigation, did not address the resident's ADL needs. Review of the resident's shower sheets, dated 4/1, 4/6, 4/9, 4/13, 4/20, 4/23, 4/24, 4/30, 5/4, 5/7, 5/11, 5/14, 5/16, and 5/18/26 showed:-Signed by the CNA and Charge Nurse;-No description of type of bathing or showering;-No skin issues listed;-Does the resident need his or her toenails cut? Blank. Review of the podiatrist list provided by the facility, dated 4/9/26, showed the resident was not listed.During an observation and interview on 5/17/ 26 at 8:47 A.M. and 5/19/26 at 8:55 A.M., the resident sat in his/her wheelchair. The resident exposed his/her lower legs and feet by lifting his/her pant legs. The resident's legs and feet were extremely dry with a dark skin discoloration to the calf area of the legs. The resident's hair was oily. The resident said he/she required assistance getting in the shower room because there was a lip when you entered the shower and he/she was afraid he/she was going to trip and fall because of it. The resident said he took a bird bath and washed his/her hair at the sink located in his/her room. He/She had not received assistance from staff for his/her showers. The resident's toenails were approximately one half an inch long and were jagged. The resident said no staff member had ever provided any type of toenail trimming or foot care since he/she had been admitted . Observation on 5/17/26 at 10:00 A.M., 5/18/26 at 9:00 A.M., and 5/19/26 at 1:05 P.M., showed the shower room had an uneven bump located directly before the shower stall. During an interview on 5/21/26 at 10:50 A.M., CNA L said the resident required assistance with his/her showers and he used his/her walker to get into the showers. The facility nail clippers were so flimsy that they were not useful in cutting the resident toenails. If staff could not cut resident's toenails, then the resident should be referred to the podiatrist. If a resident required a bed bath, then it should be written on the shower sheet as a bed bath. Foot care should be provided on their shower days and as needed. All skin issues including dry skin should be on the resident's shower sheets. 3. Review of Resident # 2's quarterly MDS, dated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], showed:-Cognitively intact;-No rejection in care;-Requires partial to moderate assistance with personal hygiene and bathing;-Requires supervision or touch assist putting on and takin off footwear;-Diagnoses included, schizophrenia (a mental condition that distorts reality), infection of intravertebral disc (a part of the back), malnutrition (poor nutrition), and viral hepatitis (inflammation of the liver caused by a virus). Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident is at risk for ADL self-care performance deficit due to deconditioning;-Interventions: Encourage the resident to participate to the fullest extent with each interaction. Monitor and document any changes, any potential for improvement, reason for self-care deficit, expected course or declines in function. Praise all efforts of self-care. Review of the resident's shower sheets, dated 4/2, 4/9, 4/13, 4/16, 4/20, 4/24, 4/27, 4/30,5/4, 5/7, 5/11, 5/14, and 5/18/26 showed:-Signed by the CNA and Charge Nurse;-No description of type of bathing or showering. Observation on 5/17/ 26 at 10:10 A.M., 5/18/26 at 9:05 A.M. and 5/19/26 at 8:45 A.M., showed the resident lay in bed. The white fitted bed sheet had stains and dark discoloration. The resident wore white socks and the bottom of the socks were stained black. The resident's hair was messy and had white particles in it. During an interview on 5/17/26 at 10:10 A.M., the resident said he/she didn't take showers any longer because the shower room on the 200 hall was so filthy. The facility did not provide any type of shoes to wear in the shower, and he/she did not want to put his/her bare feet directly on the shower floor. The resident said he required assistance with his/her showers because he/she was unsteady on his/her feet. The resident could not remember the last shower he/she took at the facility. Observation on 5/17/26 at 10:00 A.M., 5/18/26 at 9:00 A.M., and 5/19/26 at 1:05 P.M., showed the shower room on 200 hall had multiple used wet towels and had a moldy odor. There was mold on the tile grout on the wall of the shower. During an interview on 5/21/26 at 10:50 A.M., CNA L said the resident refused his/her showers and always had an excuse. The CNAs should document refusals of resident showers on the shower sheets. The facility did not supply any type of shower shoes. The resident should be encouraged to change his/her soiled socks, but the resident had a tendency to refuse care. 4. During an interview on 5/21/26 at 2:22 P.M., the Regional Nurse Consultant (RNC) and the Director of Nursing (DON) said the residents were expected to get showers two to three times a week. They would expect staff to complete accurate documentation of the showers to include what type of bathing activity occurred and any skin or foot issues. Foot care could be provided by staff and included toenail trimming and moisturization of the feet. It was expected that staff helped the residents with showers when the resident's needed assistance. The facility did not provide any type of shower shoes for the residents to wear. 5. Review of Resident #55's quarterly MDS, dated [DATE], showed:-Diagnoses included hypertension (high blood pressure), depression and anxiety;-Cognitively intact. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: Resident has an activities of daily living(ADL) self-care performance deficit;-Desired outcome: Resident will maintain current level of function by the review date;-Interventions: Eating: Resident requires supervision or touching assistance from staff to perform this task. Review on 5/17/26 at 11:14 A.M., of the resident's POS, dated 5/2026, showed an order, dated 9/30/24 for regular diet, regular food texture, thin/regular drink consistency. Observation on 5/20/26, of the resident in the main dining room, showed:-At 7:59 A.M., the resident was in the dining room for breakfast. The resident had a carton of milk, bowl of cereal, plate of scrambled eggs, a piece of toast, and a sausage patty;-At 8:02 A.M., the resident was struggling to open the milk carton. The resident, who was seated at the table with him/her, opened the milk carton for him/her. CNA B was in the dining room speaking with other residents;-At 8:16 A.M., the resident started to eat the hot breakfast portion. He/She struggled to use his/her fork with his/her hand visably shaking. He/She started to shovel the scrambled eggs onto the fork with his/her hands;-At 8:17 A.M., the resident pushed the remainder of the scrambled eggs onto the piece to toast. The resident brought his/her head down to the piece of toast to take a bite and appeared to struggle with lifting the piece of toast all the way to his/her mouth. During an interview on 5/20/26 at 12:24 P.M., the Registered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for 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** Based on interview and record review, the facility failed to provide necessary care and services for two residents (Resident #101 and #104) by failing to assess, monitor, and respond to signs and symptoms associated with substance use and overdose. The facility failed to ensure ongoing medical monitoring following an overdose that required Narcan (life-saving medication used to rapidly reverse opioid overdoses) administration (Resident #101). The facility failed to assess, evaluate, and implement interventions following observed behavioral changes and signs consistent with substance use or withdrawal, resulting in missed opportunities to identify and address ongoing substance related risks (Resident #104). The sample size was 20. The census was 97. Review of the facility's Residents-Possession and Use of Illegal Drugs, Marijuana and Alcohol and Drug Screen and Searches policy, revised 4/30/24, showed:-Purpose: To ensure that the Facility remains free from illegal drugs and substances as well as marijuana and alcohol. To define when and how a resident may be administered a drug screen or have their room searched;-Procedure: Illegal drugs or substances, marijuana and alcohol are not permitted;-The Facility is committed to maintaining a safe environment for every Resident. Part of this commitment is attempting to maintain an environment that is free of illegal drugs, dangerous items and other related contraband;-Use of illegal drugs creates a dangerous environment and may interfere with properly prescribed medications;-Marijuana (while legal) is not allowed in the Facility and can interfere with properly prescribed medications;-The use, consumption, possession, transportation, sale or distribution of unlawful or unauthorized drugs (including marijuana), inhalants, alcohol, or the abuse of prescribed drugs or alcohol by any Resident while in the Facility or on Facility property is expressly prohibited and may result in an immediate discharge. Illegal or controlled substances (other than a valid prescription) will be confiscated and the appropriate law enforcement agency(s) may be notified;-Contraband includes weapons of any kind, any items which could be used as a weapon, illegal or unauthorized drugs (including marijuana), drug paraphernalia, or alcohol. The possession or sale of any contraband while on Facility premises is expressly prohibited;-The Administrator and Director of Nursing (DON) shall educate staff and Residents (as appropriate) on the signs and symptoms of illegal drug use;-Process when suspicion of ingestion of illegal substance: If a Resident is suspected of taking an illegal drug or other substance (including marijuana), the Resident shall immediately be placed on one-on-one supervision and the Director of Nursing or charge nurse and Administrator notified;-If the Resident shows any signs of distress or there are other concerns, 911 shall be called immediately;-The nurse shall immediately evaluate the Resident and obtain a complete set of vital signs, including a neurology check and oxygen saturation level;-The Resident's primary care physician shall immediately be contacted for instructions;-If the Resident is not being sent to the hospital, the protocol below for drug screens and searches will apply;-Drug Screen: In the event the Administrator or DON has reasonable suspicion that a Resident has ingested illegal or unauthorized drugs, a drug screen may be administered;-Search of Resident's room or property: In the event the Facility's Administrator or DON has reasonable suspicion that contraband, illegal drugs or something that poses a safety risk to the Resident or others in the Facility is in a Resident's room, a search of the Resident's room may be considered;-The Facility should not act as an arm of law enforcement and may instead of a search (or if consent is not given for a search), the facility may make a referral will be made to local law enforcement;-If the Resident is his/her own person, the resident must consent to the search. If the Resident refuses the room or property search, the search will not be conducted and the Management Company Regional Director will be notified;-If suspected illegal drugs are found, the local police and the Department of Health and Human Services will be notified. The RCMC Regional Director will also be notified;-Suspected Contraband or illegal Drugs: If suspected contraband or illegal drugs (including marijuana) are found, those items will be given to the Administrator, Director of Nursing or Charge (continued on next page)

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	265668	A. Building B. Wing	05/21/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident states he/she gave the other resident Fentanyl in exchange for meth he/she had purchased from the supplier. The resident consented to let officer look at his/her phone. The police seized the resident's two telephones and stated that forensics would need to be run on them. The responding officer stated they will be applying for warrants on the charge of 2nd degree drug trafficking and took the resident into custody. The resident's medication list was provided to the officer, so they were aware of the legal prescriptions he/she has;-On 4/20/26 at 7:26 P.M., resident's emergency contact notified of resident being taken into custody by the Police Department pending drug charges;-On 4/20/26 at 8:00 P.M., immediate discharge served to this resident at hospital at approximately 8:00 P.M. Discharging to the custody of the Police Department. Review of the resident's police report, dated 4/20/26, showed:-Incident nature: Drugs/Narcotics;-Incident Summary: Trafficking drugs, 2nd degree;-Arrestee arrested;-Original Narrative: Upon our arrival, we were met by employees who stated at approximately 0900 hours, Resident #105 had overdosed in their establishment and conveyed to the hospital. Due to those circumstances, the employees conducted room checks to ensure there was no other narcotics. DON conducted a search in room where offender Resident #104 resided and located multiple opened and unopened capsules, a bag containing a crystal-like substance the size of small rocks, and an empty plastic bag containing small traces of a powdery substance. DON removed the narcotics, placed them in a separate container, held the narcotics in the office guarded by employees, and contacted police;-Resident #104 admitted the narcotics were retrieved from his/her black bag inside his/her room. The resident originally stated he/ she had the narcotics approximately four months ago before he/she began residing at facility. When I inquired about Resident #105 overdose, he/she stated the drugs were not received from him/her and he/she never gave them out to anybody else. When I inquired where the drugs were bought from, the resident stated he/she received them from his/her dealer. When I inquired about how he/she gets into contact with him/her, the resident used his/her cellphone to provide me with the cellphone number he/she calls him from along with his Chime username and recent transactions. Looking at the transactions I observed the last payment was on April 19, 2026. When I asked the resident about the recent transaction, he/she admitted she did buy narcotics from dealer;-When I asked the resident about his/her relationship with Resident #105 he/she stated he/she knows of him/her, but they did not have a close relationship;-At the time I was questioning the resident, officers found a capsule inside the resident's purse. Officer #1 located was an enclosed capsule and Officer #2 found half of a capsule;-Administrator advised me after Resident #105 overdose, he/she was approached by witness who told him/her about a weird interaction between Residents #104 and #105;-The following is a synopsis of statements from witness: Witness stated he/she resides in the room right next to Resident #104. At approximately 0300 hours, witness was woken up by Resident #104 and Resident #105 who were speaking loudly. Witness heard Resident #105 directly state [NAME] get that to which Resident #104 declined. Witness entered the room to find out what was going on and Resident #104 told him/her it was nothing and offered him/her money to buy a soda;-It should be noted witness stated Resident #104 and Resident #105 were known to be around each other frequently and appeared to be under the influence;-When I returned to speak with Resident #104 he/she admitted he/she did spend more time with Resident #105 than he/she originally stated. He/She also stated last night, he/she was not feeling well and had Resident #105 pick up the capsules for him/her and brought them back to him/her;-Narrative: Due to lab results that is attached to the report, Resident #104 was issued with th

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	265668	A. Building B. Wing	05/21/2026

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 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, assess, monitor, and address behavioral health needs related to substance use disorder for residents with known history of substance abuse, including a thorough review of the referral information identifying recent substance use and positive toxicology results. The facility also failed to implement appropriate behavioral health interventions, monitoring, and services during a period in which social services staff were unavailable, resulting in missed opportunities to identify relapse risk, escalating warning signs, and ongoing substance use within the facility (Residents #104, #105, and #101). The resident sample was 20. The census was 97. The administrator was notified on [DATE], of the past non-compliance. The facility educated staff on incidents and accidents, screening resident's belongings, notifying physicians of resident changes in health, residents being in possession of illegal drugs, and the leave of absence policy. The facility also began monitoring and documenting behaviors associated with illegal substance use. The deficiency was corrected on [DATE].Review of the facility's Behavioral Health Service Policy, revised [DATE], showed:-Substance Use Disorder (SUD): Substance use disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home;-Policy: The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment;-The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;-Assessment/Care planning: The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Staff will:--Complete PASRR screening;--Obtain history from medical records, the resident, and as appropriate the resident's family and friends, regarding mental, psychosocial, and emotional health;--Monitor the resident closely for expressions or indications of distress;--Evaluate whether the resident's distress was attributable to their clinical condition and demonstrate that the change in behavior was unavoidable;--Utilize MDS and care area assessments;--Assess and develop a person-centered care plan for concerns identified in the resident's assessment;--Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes, including differential diagnosis;--Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;--Ensure appropriate follow-up assessment, if needed;--Discuss potential modifications to the care plan;--Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident;-The resident, and as appropriate the resident's family, are included in the comprehensiveassessment process along with the interdisciplinary team and outside sources, as indicated. The care plan shall:--Provide for meaningful activities which promote engagement and positive,meaningful relationships. Residents living with mental health and SUDs may require different activities than other nursing home residents. The facility will ensure thatactivities are provided to meet the needs of these residents;--Address any other individualized needs the resident may have related to the mental disorder or the SUD;--Behavioral contact: If a behavioral contract is used, it will only be used with residents who have the capacity to understand it. A contract will only be used as a method of encouraging the resident to follow their plan of care, and not as a system of reward and punishment. The contract will not conflict with resident rights or other (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	requirements of participation;--Resident refusal to accept, or non-adherence to the terms of a behavioral contract, will not be the sole basis for a denial of admission, transfer or discharge. Review of the facility's Residents- Possession and Use of Illegal Drugs, Marijuana and Alcohol and Drug Screen and Searches policy, revised [DATE], showed:-Purpose: To ensure that the Facility remains free from illegal drugs and substances as well as marijuana and alcohol. To define when and how a resident may be administered a drug screen or have their room searched;-Procedure: Illegal drugs or substances, marijuana and alcohol are not permitted;-The Facility is committed to maintaining a safe environment for every Resident. Part of this commitment is attempting to maintain an environment that is free of illegal drugs, dangerous items and other related contraband;-Use of illegal drugs creates a dangerous environment and may interfere with properly prescribed medications;-Marijuana (while legal) is not allowed in the Facility can interfere with properly prescribed medications.-The use, consumption, possession, transportation, sale or distribution of unlawful or unauthorized drugs (including marijuana), inhalants, alcohol, or the abuse of prescribed drugs or alcohol by any Resident while in the Facility or on Facility property is expressly prohibited and may result in an immediate discharge. Illegal or controlled substances (other than a valid prescription) will be confiscated, and the appropriate law enforcement agency(s) may be notified;-Contraband includes weapons of any kind, any items which could be used as a weapon, illegal or unauthorized drugs (including marijuana), drug paraphernalia, or alcohol. The possession or sale of any contraband while on Facility premises is expressly prohibited;-The Administrator and Director of Nursing shall educate staff and Residents (as appropriate) on the signs and symptoms of illegal drug use;-Process when suspicion of ingestion of illegal substance: If a Resident is suspected of taking an illegal drug or other substance (including marijuana), the Resident shall immediately be placed on one-on-one supervision and the Director of Nursing or charge nurse and Administrator notified;-If the Resident shows any signs of distress or there are other concerns, 911 shall be called immediately;-The nurse shall immediately evaluate the Resident and obtain a complete set of vital signs, including a neurology check and oxygen saturation level;-The Resident's primary care physician shall immediately be contacted for instructions;-If the Resident is not being sent to the hospital, the protocol below for drug screens and searches will apply;-Drug Screen: In the event the Administrator or Director of Nursing has reasonable suspicion that a Resident has ingested illegal or unauthorized drugs, a drug screen may be administered;-Search of Resident's room or property: In the event the Facility's Administrator or Director of Nursing has reasonable suspicion that contraband, illegal drugs or something that poses a safety risk to the Resident or others in the Facility is in a Resident's room, a search of the Resident's room may be considered;-The Facility should not act as an arm of law enforcement and may instead of a search (or if consent is not given for a search), the facility may make a referral will be made to local law enforcement;-If the Resident is his/her own person, the resident must consent to the search. If the Resident refuses the room or property search, the search will not be conducted, and the Management Company Regional Director will be notified;-If suspected illegal drugs are found, the local police and the Department of Health and Human Services will be notified. The Regional Director will also be notified;-Suspected Contraband or Illegal Drugs: If suspected contraband or illegal drugs (including marijuana) are found, those items will be given to the Administrator, Director of Nursing or Charge Nurse for inventory;-All items will be placed in a secure location for all Residents' safety;-Suspected illegal drugs will be turned over to law enforcement personnel for safe disposal;-Increased Oversight: To protect the health and safety of residents, the facility will provide additional monitoring and supervision, which includes denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility. 1. Review of Resident #104's hospital record, showed:-admitted [DATE]; -Assessment and Plan: Opioid withdrawal: Present on admission;-Sinus tachycardia (heartbeat over 100 beats per minute): Present on admission;-Fentanyl (potent, synthetic opioid drug) use disorder, severe: Present on admission;-Polysubstance use disorder: Present on admission;-Most likely etiology of discomfort at this time was relating to opiate withdrawal given (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	his/her recent initiation of suboxone (used to treat opioid use disorder) and subjective history of mild improvement when using unspecified pill, presumed to be fentanyl (highly potent synthetic opioid) in an outpatient setting although unable to fully rule out component of known rheumatologic conditions;-Plan of care discussion: We reviewed his/her symptoms at the bedside and discussed that based on his/her story and the lab studies he/she performed, at this point that the most likely cause of his/her current pain was opiate withdrawal;-Physician progress note: He/She denied any issues with drug cravings. He/She was worried about managing his/her pain. The Buprenorphine (long-acting partial opioid agonist used to treat opioid use disorder) did not seem to be taking the edge off his/her pain. He/She would like to try methadone (long-acting synthetic opioid used to treat opioid use disorder). We discussed prolonged QT syndrome (a heart rhythm disorder) and strict federal regulations that both prohibit the use of methadone for him/her. He/She confirmed understanding and agreed with the plan to decrease buprenorphine to allow greater efficacy of the breakthrough pain meds;-The resident presented to hospital for chest pain on the initial workup for cardiac and musculoskeletal causes was unremarkable. Suspicion was raised for possible opiate withdrawal caused his/her pain. Review of the resident's face sheet, showed:-admitted [DATE];-Diagnoses of hemiplegia, hemiparesis, and cerebral infarction. Review of the resident's initial psychosocial history, dated [DATE], showed:-Substance Abuse;-Current stressors: blank;-Current diagnosis: blank;-Psychosocial assessment: Change in sleep and increased anxiety;-Past history: Suicidal ideations/attempts;-Self injurious behavior: non-suicidal;-Methods of self-injurious behavior: cutting;-Socialization and support system: Other: staff;-IDT signatures: blank. Review of the resident's care plan, dated 3/23 and revised [DATE], showed:-Problem: The resident was at risk for polysubstance abuse related to substance seeking behavior/safety risk;-Interventions: Administer Narcan per physician's order for signs/symptoms of narcotic overdose;-Monitor for signs of substance abuse/intoxication;-Monitor for signs of withdrawal;-Monitor items brought into the facility;-Offer emotional support during periods of agitation;-Notify physician of refusal or noncompliance;-Offer resident in the room alcoholic anonymous (AA)/ Narcotics anonymous (NA) program;-Problem: The resident is at risk for intentional or unintentional overdose due to history of depression, anxiety, confusion, access to medication substance misuse;-Interventions: Education provided on illegal drug use policy for the facility, Screens and search entering the building, resident possession and use of drug/alcohol policy, Adverse drug event policy, Narcan use policy, residents rights, abuse and neglect policy, and metal wand upon entering the building. Review of the resident's Physician Order Sheet (POS), dated [DATE] through [DATE], showed:-An order, dated [DATE], Hydromorphone (semi-synthetic opioid analgesic used to treat pain) HCl oral tablet 4 mg. Give one tablet by mouth every four hours as needed for pain;-An order, dated [DATE], Hydroxyzine (used to treat anxiety) HCl oral tablet 25 mg. Give 25 mg by mouth every six hours as needed for anxiety. Take one tablet by mouth four times daily as needed for anxiety;-An order, dated [DATE], Methocarbamol (muscle relaxer) Oral tablet 500 mg. Give 500 mg by mouth every six hours as needed for muscle spasms;-An order, dated [DATE], Narcan (lifesaving spray that reserves an opioid overdose) Nasal Liquid 4 mg / 0.1 milliliter (ml). Spray one spray into the nose as needed for overdose;-An order, dated [DATE], hydroxyzine HCl Oral Tablet 25 mg. Give 25 mg by mouth every six hours for anxiety;-An order, dated [DATE], Hydrocodone-Acetaminophen (used to treat pain) Oral Tablet 5-325 mg. Give one tablet by mouth three times a day for pain;-An order, dated [DATE], Trazodone (anti-depressant) HCl Oral Tablet 50 mg. Give one tablet by mouth at bedtime for insomnia;-An order, dated [DATE], hydroxyzine HCl oral tablet. Give 50 mg by mouth two times a day for anxiety;-An order, dated [DATE], hydroxyzine HCl oral tablet. Give 50 mg by mouth two times a day for anxiety until [DATE]. Review of the resident's progress notes, dated [DATE], showed:-Resident continued to exhibit erratic behavior and signs of withdrawal, though he/she denies experiencing any symptoms. Significant safety concerns are noted as the resident repeatedly slides out of his/her wheelchair and engages in self-picking, resulting in a sore on his/her face. Nursing attempted to perform a clinical evaluation and (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	facilitated a telehealth visit with the physician; however, the resident refused both, stating he/she did not wish to speak with the physician again. The physician and Director of Nursing (DON) have been notified of the resident's behavior, his/her refusal of care, and his/her request regarding the physician. Staff will continue to monitor closely for safety and skin integrity.-Further review of the progress notes did not show staff spoke with the physician regarding the resident exhibiting signs of withdrawal of illegal substances. During an interview on [DATE] at 3:48 P.M., Licensed Practical Nurse (LPN) A confirmed he/she wrote the progress note on [DATE]. In his/her opinion, the resident was acting erratic. He/She was offered suboxone, but refused it. It helped with withdrawals. The resident started picking at him/herself and tried to act sane so LPN A would not suspect behaviors. The physician and psychiatrist were contacted. The psychiatrist saw the resident, but there was no way to redirect the resident. LPN A was asked to clarify why withdrawal was documented. LPN A said the resident was withdrawing from street drugs. He/She had an opioid abuse history before he/she was admitted . When the resident was first admitted , he/she was not exhibiting any behaviors, then he/she started to act erratic or self- medicate. Some behaviors included crying hysterically because of pain. They administered pain medication to him/her. One day, LPN A saw a lunch bag in the resident's room, and he/she never let anyone touch it. LPN A did not believe anyone searched his/her bag. Even during room search, an aide needed to search room, but the resident took the bag with him/her and held on to it. The resident was arrested at the facility for illegal substances on [DATE] and the bag was searched. He/She only had one visitor. When LPN A spoke to the physician, he/she mentioned the resident had withdrawals, but did not specify from what. The physician should have known the resident was coming off opioid abuse. [DATE] was the first time LPN A witnessed this behavior from the resident. Before, he/she cried about his/her arthritis. It felt like he/she was drug seeking. The resident would say I want to get out of here and he/she was better off on the streets. He/She was referred to pain management, but he/she did not go. Immediately the resident said he/she would rather go AMA (Against Medical Advice). As far as he/she knew, the resident was prescribed and never refused suboxone. Suboxene was found on him/her during the search. The pill was supposed to sit under the tongue, but LPN A believed the resident was taking it out when staff left the room after administering the medication. The resident took the other pills that were administered in front of staff, but placed the suboxone under the tongue and moved away. During an interview on [DATE] at 3:41 P.M., Certified Nurse Aide (CNA) J said Resident #104 was always in his/her room and he/she had only seen him/her come out about two or three times. He/She was in pain because the resident said he/she was coming off withdrawals from street drugs. CNA J was not sure what drugs, but the resident was on hard drugs. The resident would always sleep. He/She would sleep in his/her wheelchair leaned over the bed. CNA J was not sure if he/she was under the influence. During an interview on [DATE] at 12:19 P.M., the Assistant DON (ADON) said on [DATE], the behavior they were trying to identify was related to pain versus withdrawal. It was believed to be withdrawal because of the resident's substance abuse history. The resident could not identify where the pain was located, whether it was the hip, knee, or if it was arthritic pain. He/She started to get behaviors, and he/she could not identify what was hurting him/her. The resident declined to go to the hospital. They were juggling to see what was wrong. The physician was notified and said he/she would be in to see the resident. The physician would not approve any medication until he/she saw the resident and provided a signature. The resident did not want suboxone. The resident had a face to face with the physician and went against the medication. The ADON recalled he/she refused to take the suboxone. When asked about behaviors related to substance use or bringing illegal substances into the facility, the ADON said the resident only had one visitor. Per facility policy, if they found contraband, they called the authorities. The resident refused treatment. An aide reported at one point seeing the resident on the floor. The resident was abrasive at the time and a plastic bag was seen on the floor. The ADON said the aide no longer worked at the facility. During an interview on [DATE] at 12:56 P.M., Physician P said he/she remembered the resident, and (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	he/she was one of the hard ones. The resident used to ask for narcotics, and they referred him/her to the pain clinic. He/She refused medications at times, even the suboxone. He/She also threw tantrums. Staff reported the resident's refusals, but there was also a psych component as well. On [DATE], he/she was aware of the resident's erratic and odd behaviors in an attempt to get his/her way. Physician P did not hear them say withdrawal. It was not physical, it was more psych. The resident did things to get things. Physician P would have expected to be informed the resident may have been going through withdrawal. If the resident was believed to have withdrawal symptoms, he/she would have sent the resident to the hospital, did a drug screen, and continued to monitor and document. Review of the resident's [DATE] progress notes showed:-On [DATE] at 2:46 P.M., call placed to Physician P for a teledoc/or in-house visit related to patient behaviors, suspected drug use, and possession of illegal substance. The resident refused room sweep which was conducted due to suspected substance abuse. Patient became irate, demanding to sign AMA form. The resident became aggressive, screaming and resistant. Crises prevention intervention (CPI) became in progress by CPI certified staff. The resident screamed that he/she would rather be homeless on the street than in pain and would like the regimen that he/she had while in the hospital. He/She admitted being clean for a few months and had used recently Fentanyl and [NAME] Meth. He/She requested a physician to review pain regime; -On [DATE] at 4:30 P.M., the resident consented to having his/her purse searched by the DON, with Regional Director of Operations (RDO) as witness. During the search there were multiple opened capsules, which appeared to be empty, and multiple capsules which appeared to be intact. There was also a baggie in the resident's purse which contained a crystallized substance which appeared to be clear in color, and white powder in the bottom of the baggie. The resident stated the substances found in his/her purse were Fentanyl and Methamphetamine. The resident was asked if he/she had given any residents any of the narcotics and he/she stated he/she had not. Police Department was notified of the suspected narcotics found on the resident and summoned to the facility. The narcotics were transferred to officers' possession. Officer then conducted another search of the resident's room and found an additional capsule. The Officer interviewed the resident. The resident admitted to the Officer that last evening, he/she sent money to the supplier of the narcotics and asked another resident to sign out and retrieve the narcotics for him/her. The resident stated he/she gave the other resident Fentanyl in exchange for meth he/she had purchased from the supplier. The resident consented to let the Officer look at his/her phone. The police seized the resident's two telephones and stated that forensics would need to be run on them. The responding officer stated they will be applying for warrants on the charge of 2nd degree drug trafficking and took the resident into custody. The resident's medication list was provided to the officer, so they were aware of the legal prescriptions he/she had;-On [DATE] at 7:26 P.M., resident's emergency contact notified of resident being taken into custody by the Police Department pending drug charges;-On [DATE] at 8:00 P.M., immediate discharge served to this resident at hospital at approximately 8:00 P.M. Discharging to the custody of the Police Department. Review of the resident's police report, dated [DATE], showed:-Incident nature: Drugs/Narcotics;-Incident Summary: Trafficking drugs, 2nd degree;-Arrestee arrested;-Original Narrative: Upon our arrival, we were met by employees who stated at approximately 0900 hours, Resident #105 had overdosed in their establishment and went to the hospital. Due to those circumstances, the employees conducted room checks to ensure there was no other narcotics. DON)conducted a search in room where Resident #104 resided and located multiple opened and unopened capsules, a bag containing a crystal-like substance the size of small rocks, and an empty plastic bag containing small traces of a powdery substance. DON removed the narcotics, placed them in a separate container, held the narcotics in the office guarded by employees, and contacted police;-Resident #104 admitted the narcotics were retrieved from his/her black bag inside his/her room. The resident originally stated he/she had the narcotics approximately four months ago before he/she began residing at facility. When officer inquired about Resident #105 overdose, he/she stated the drugs were not received from him/her and he/she never gave them out to anybody else. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	When officer inquired where the drugs were bought from, the resident stated he/she received them from his/her dealer. When officer inquired about how he/she gets into contact with him/her, the resident used his/her cellphone to provide officer with the cellphone number he/she calls him from along with his/her Chime username and recent transactions. Looking at the transactions officer observed the last payment was on [DATE]. When officer asked the resident about the recent transaction, he/she admitted he/she did buy narcotics from dealer;-When officer asked the resident about his/her relationship with Resident #105 he/she stated he/she knows of him/her, but they did not have a close relationship;-At the time officer was questioning the resident, officers found a capsule inside the resident's purse. Officer #1 located an enclosed capsule and Officer #2 found half of a capsule;-Administrator advised officer after Resident #105 overdose, he/she was approached by witness who told him/her about a weird interaction between Residents #104 and #105;-The following was a synopsis of statements from witness: Witness stated he/she resides in the room right next to Resident #104. At approximately 0300 hours, witness was woken up by Resident #104 and Resident #105 who were speaking loudly. Witness heard Resident #105 directly state [NAME] get that to which Resident #104 declined. Witness entered the room to find out what was going on and Resident #104 told him/her it was nothing and offered him/her money to buy a soda;-It should be noted witness stated Resident #104 and Resident #105 were known to be around each other frequently and appeared to be under the influence;-When officer returned to speak with Resident #104 he/she admitted he/she did spend more time with Resident #105 than he/she originally stated. He/She also stated last night, he/she was not feeling well and had Resident #105 pick up the capsules for him/her and brought them back to him/her;-Narrative: Due to lab results that is attached to the report, Resident #104 was issued with three counts of Possession of a Controlled Substance. Review of the Crime Laboratory Controlled Substance Analysis showed:-Item #1: One red/blue capsule containing white power removed. Lab results showed Fentanyl was the identified substance;-Item #8: One white oblong tablet: Methocarbamol (a muscle relaxant) 500 mg;-Item #13: One round white tablet: Hydroxyzine HCl 25 mg;-Item #16: One round white tablet: Trazodone HCl 50 mg;-Item #17: One oval peach tablet: Buprenorphine HCl 2 mg. Numerous tablets appeared to have been degraded and wet at some point. The tablet pieces and powder were included with the whole tablets based on shape and color;-Item #18: One round off-white tablet with no markings removed. Lab results showed Levorphanol (opioid pain medication) was identified;-Item #21: Numerous loose capsules with residue, debris, a piece of metal, and one knotted disposable glove containing a capsule half with residue;-Item #22: One plastic zipper pouch with residue;-Item #23: One twisted plastic bag containing clear crystals;-Contained a total weight of 3.38 grams. Lab results showed Methamphetamine was identified. Further review of Resident #104's face sheet, showed on [DATE], a diagnosis of opioid abuse was added to the medical record. During an interview on [DATE] at 12:19 P.M., the Administrator and ADON said after another resident's overdose (Resident #105), it initiated a room search. It led to finding drugs on Resident #104. During an interview on [DATE] at 12:19 P.M., the DON said they did a room sweep. Resident #104 got irate and said no to the search and covered his/her bag. He/She wanted to leave and said, let me go. They asked where he/she wanted to go, and the resident said the hospital or the streets. The resident said he/she did not want to be there anymore and did not want to be sick. They told the resident they needed to see what was in the bag. He/She was advised of his/her rights, but he/she was still a resident. They confiscated the bag and saw what was in it. There was a crystalized, hard substance, like crystal meth. There were pills that were popped in the bag. There was a form of suboxone on him/her. It was the kind they were supposed to administer to him/her. The resident admitted he/she received it from an outside source. During an interview on [DATE] at 12:19 P.M., the ADON said on [DATE], the police did a test on what was found, and they arrested the resident. They found enough on the resident to consider it trafficking. The police confirmed Fentanyl was found. There were a lot of capsules, some were already popped. There was a baggie that had a solid crystal piece inside. There was a team of five officers, and it activated more police. It was only (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	05/21/2026

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 0740 Level of Harm - Actual harm Residents Affected - Few	found in his/her room. They questioned the resident and asked if he/she gave it to another resident. It could only be assumed because the other resident went to the hospital that day with a lot of issues. The ADON said the officers allowed the resident to smoke and during that time, he/she gave the description of the dealer, phone number, card transaction, and which gas station he/she met the dealer. The resident turned in a second phone. During an interview on [DATE] at 12:19 P.M., the DON said they found out Resident #104 and another resident who ended up overdosing (Resident #105) spent a lot of time together the evening before the resident was arrested. 2. Resident #105's face sheet, showed:-admitted on [DATE];-Diagnoses included other psychoactive substance abuse and homelessness. Review of the resident's POS, dated [DATE] through [DATE], showed an order, dated [DATE], Narcan nasal liquid 4 milligrams (mg), alternating nostrils every six hours as needed for overdosing. Review of the resident's progress notes showed:-On [DATE] at 8:55 A.M., writer called to resident room by CNA due to acute change in condition. Upon arrival, resident found slumped over in wheelchair, unresponsive to verbal and vigorous tactile stimuli. Respirations noted labored and irregular. Code initiated immediately. At 8:59 A.M., 911 activated via cell phone. Assessment completed: Blood glucose: 144 (normal range 70 to 99) saturation: 82% (normal range 95 to 100) on 5 liters (L) oxygen via nasal cannula. The resident was transferred to bed with assistance of multiple staff. Naloxone (Narcan) administered intranasally x 2 per physician order. The resident continued with sporadic, labored respirations and minimal response to continued verbal/tactile stimulation. Cool towel applied and stimulation measures continued in attempt to arouse. Fire department followed by Emergency Medical Service (EMS) arrived and assumed care. At time of transfer to stretcher, resident noted moaning and rubbing chest; however, remained not alert/oriented. Physician notified;-On [DATE] at 9:17 A.M., the patient was his/her own responsible party, physician made aware, EMS on site, Cardiopulmonary Resuscitation (CPR, lifesaving procedures) initiated. Rescue position heart rate 255 (normal range 60 to 100), blood sugar 144, oxygen 82 on 5 L resident with history of diabetes, acute kidney failure, and polysubstance abuse;-On [DATE] at 9:29 A.M., the resident was administered two Narcan for both nares (nostrils), resident remained unresponsive. The resident was transported to the hospital via EMS;-On [DATE] at 12:36 P.M., the resident was at the hospital;-On [DATE] at 5:10 P.M., the patient had low PH (substance or solution is acidic). He/She was stable for now on a Narcan drip. The patient would most likely be admitted for continued treatment evaluation monitoring. Review of the resident's care plan, revised on [DATE], showed:-Problem: Resident had received and has been educated on facility illegal drug policy;-Interventions: Monitor for changes in behavior;-Monitor for increased or unexplained drowsiness, lack of coordination, slurred speech, mood changes, or loss of consciousness;-Offer the resident the in the room Alcoholic's Alcoholics Anonymous (AA) program;-Problem: [DATE], resident had an actual overdose;-Interventions: 911 initiated;-Administer medications per physician orders;-Notify physician;-Psych consult upon return to facility;-Initiate facility emergency protocol;-Room checks per facility policy;-Administered Narcan (life lifesaving medication used to rapidly reverse opioid overdoses) per physician order;-Offer resident in the room AA/Narcotic's Anonymous (NA) program;-Problem: Resident at risk for polysubstance abuse related to substance-seeking behavior/safety risk;-Interventions: Monitor for signs of substance abuse/intoxication;-Monitor for signs of withdrawal;-Monitor items brought into facility;-Offer emotional support during periods of agitation;-Notify physician of refusal or noncompliance;-Offer resident in the room AA/NA program;-Problem: Resident is at risk f[TRUNCATED]