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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Home	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 37672 40290 Based on observation, interview and record review, the facility failed to ensure residents were assessed to self-administer medications and physician orders were maintained for self-administration of medication for two residents observed with medications left at the bedside (Residents #42 and #62) and one resident who was not adequately supervised during medication administration (Resident #77). The sample was 18. The census was 79. Review of the facility's Self-Administration of Medications policy, revised February 2021, showed: -Policy Statement: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so; -Policy Interpretation and Implementation: -As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident; -If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status; -Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them; -Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. 1. Review of Resident #42's medical record, showed: -Able to make needs and wants known; (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included kidney disease, high blood pressure, and kidney failure. Review of the resident's physician order sheet (POS), dated 6/2024, showed an undated order for Flonase (used to treat sinus allergies) nasal spray 50 micrograms (mcg), inhale one spray in each nostril daily. Review of the chart, on 6/24/24 at 9:23 A.M. and 2:15 P.M., and 6/25/24 at 8:25 A.M., showed no orders or assessment for medication self-administration. Observation on 6/24/24 at 1:35 P.M., and 6/25/24 at 8:28 A.M., showed a bottle of Flonase next to the resident's bedside. During an interview on 6/25/24 at 11:22 A.M., the resident said he/she used the Flonase during the day. Staff had not provided an assessment or education regarding the medication. Review of the POS on 6/25/24, showed a new order at 1:05 P.M., the resident may keep Flonase nasal spray at the bedside. 2. Review of Resident #62's medical record, showed: -Able to make needs and wants known; -Diagnoses included shortness of breath, heart disease, high blood pressure, vascular disease, stroke, dementia, anxiety, and depression. Review of the resident's POS, dated June 2024, showed: -An order for Atrovent (used for shortness of breath) inhaler, take two puffs three times a day; -An order for Albuterol (used for shortness of breath) inhaler, take two puffs three times a day. Observations of the resident's room on 6/24/24 at 9:45 A.M. and 2:10 P.M., and 6/25/24 at 7:10 A.M. and 12:50 P.M. and 6/26/24 at 7:01 A.M., showed both inhalers in a plastic bag on top of the resident's bedroom dresser. Review of the resident's medical record, showed the resident had no current medication self-administration orders and did not have a current medication self-administration assessment completed. During an interview on 6/27/24 at 10:05 A.M., the resident said he/she uses the inhalers during the day at various times. 3. Review of Resident #77's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/30/24, showed: -Cognitively intact; -Diagnoses included high blood pressure, chest pain, viral infection, anxiety, depression, sleep disorder, and adjustment disorder with mixed anxiety and depressed mood. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 5/30/24 and in use at the time of survey, showed: -Problem: Potential for alteration in cognitive function thought process. Confusion/disorientation, memory loss, distractibility, hallucinations, delusions, suspiciousness. Inaccurate interpretation of stimuli. Psychotropic medication; -Goals: Resident will maintain current cognitive level and continue decision making with/without help through next review; -Interventions include administer medications per physician order; -No documentation showing the resident can self-administer his/her own medications. Review of the resident's medical record, showed no assessment identifying the resident as able to self-administer his/her own medications. Review of the resident's POS and medication administration record (MAR) for June 2024, showed: -An order, dated 5/17/24, for carvedilol (used to treat high blood pressure) 25 milligrams (mg), one tab by mouth (PO) twice daily. PM dose on 6/24/24 initiated by Certified Medication Technician (CMT) F; -An order, dated 5/17/24, for acyclovir (drug used to treat herpes virus infections) 400 mg, PO twice daily. PM dose on 6/24/24 initiated by CMT F; -An order, dated 6/11/24, for Risperidol (antipsychotic) 1 mg, PO twice daily. PM dose on 6/24/24 initiated by CMT F; -An order, dated 6/11/24, for Depakote (anti-seizure medication used to treat seizures and bipolar disorder) 250 mg, PO twice daily. PM dose on 6/24/24 initiated by CMT F; -An order, dated 6/19/24, for Fanapt (antipsychotic) 2 mg, PO twice daily. PM dose on 6/24/24 initiated by CMT F; -No orders for the resident to self-administer their medications. Observation on 6/24/24 at 5:21 P.M., showed CMT F stood at a medication cart in the dining room. He/She opened pre-packaged pouches of medication and poured the contents into a plastic medication cup. He/She handed the cup of pills and a cup of water to Resident #77. Resident #77 walked away from the medication cart and walked down the hallway to the nurse's station, where no staff were present. The resident poured several pills into his/her mouth and drank water from the cup. He/She cleared his/her throat and repeated this process three more times until he/she had swallowed all medications from the cup. During an interview on 6/24/24 at 5:24 P.M., the resident said he/she is new to the facility. He/She is not sure what medications he/she is prescribed. He/She just got his/her medications from staff and took them at the nurse's station because he/she did not want to take them in the dining room. He/She is not sure if staff are supposed to watch him/her take the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 7:51 A.M., Licensed Practical Nurse (LPN) D said there are only a few residents in the facility who have been assessed to be able to self-administer their own medications, and all other residents must be supervised while taking their medication. Resident #77 cannot self-administer his/her own medication. During medication administration, staff must watch the resident take their medication due to safety reasons. Unless a resident has been assessed to be able self-administer their medication, it is not appropriate for staff to hand a resident their medication and let the resident walk away without observing them take the medication. 4. During an interview on 6/27/24 at 10:35 A.M., LPN E said residents who self-administer medications should have a physician's order in the chart. A current medication self-administration assessment should be completed prior to the medications being left with the resident. 5. During an interview with the Director of Nursing (DON) and Administrator on 6/27/24 at 10:26 A.M., the DON said if a resident wants to self-administer their medication, the nurse must contact the physician. If the physician agrees, the nurse should complete a self-administration of medication assessment. The physician's order for a resident to be able to self-administer their medication should be added to the resident's POS. The medication self-administration assessment and physician order must be in place before staff provide the resident with their medication to self-administer. If a resident does not have orders to self-administer their medications, staff must supervise the resident during medication administration. Staff should have supervised Resident #77 during his/her medication administration to ensure safety. If a resident wants to take their medication in a private area instead of the dining room, staff should accommodate this, but still make sure to supervise the medication administration.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 40290 46888 Based on interview and record review, the facility failed to ensure one resident's (Resident #7's) advanced directive matched in the hard (paper) chart and on the physician's orders sheet (POS) and that one resident (Resident #72) had a current physician's order for code status. The facility also failed to ensure the resident's advanced directives were reviewed annually (Residents #62, #25, #2, #19, #26, #41). The sample was 18. The census was 79. Review of the facility's advanced directives policy, revised [DATE] showed: -Policy: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy; -Policy implementation: The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The interdisciplinary team will be informed of changes and/ or revocations so that the appropriate changes can be made in the resident medical record and care plan. 1. Review of Resident #7's medical record, showed: -admitted : [DATE]; -Able to make needs and wants known; -Diagnoses included dementia, paranoid state, and chronic obstructive pulmonary disease (COPD, lung disease). Review of the medical record on [DATE] and [DATE], showed: -No code status listed on the face sheet; -Signed Code Status form, dated [DATE], designated Do Not Resuscitate (No Code); -Full Code status listed on the [DATE] through [DATE] physician orders. 2. Review of Resident #72's medical record, showed: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admitted [DATE]; -A code status form, checked for full resuscitation, signed by the resident on [DATE]. Review of the resident's POS from April, May, and [DATE], showed no physician's order for code status. 3. Review of Resident #62's medical record, showed: -admitted : [DATE]; -Able to make needs and wants known; -Diagnoses included heart disease, high blood pressure, vascular disease, stroke, dementia, anxiety and depression. Review of the medical record on [DATE] and [DATE], showed a signed full code status sheet, dated [DATE]. Review of the POS, dated ,d+[DATE], showed the selection of full code. Observation on [DATE] at 1:10 P.M., showed the social worker (SW) removed and replaced the code status form dated [DATE] with an updated form, dated [DATE]. 4. Review of Resident #25's medical record, showed: -admitted : [DATE]; -Able to make needs and wants known; -Diagnoses included kidney disease, high blood pressure and kidney failure. Review of the POS, dated ,d+[DATE], showed the selection of full code. Review of the medical chart on [DATE] and [DATE], showed a signed full code status sheet, dated [DATE]. Observation on [DATE] at 1:30 P.M., showed the SW removed the code status form dated [DATE] and replaced it with a form, dated [DATE] for full code. 5. Review of Resident #2's, medical record, showed: -admitted : [DATE]; -Severe cognitive impairment; -Diagnoses included: Dementia, kidney disease, skin cancer, high blood pressure and anemia. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record on [DATE], and [DATE], showed a signed full code status form, dated [DATE]. Review of the POS, dated ,d+[DATE], showed the selection of full code. 6. Review of Resident #19's medical record, showed: -admitted : [DATE]; -Severe cognitive impairment; -Diagnoses included weakness, diabetes, anemia, stroke, paralysis and cancer. Review of the POS, dated ,d+[DATE], showed an order for full code. Review of the medical chart, showed a signed full code status form, dated [DATE]. 7. Review of Resident #26's, medical record, showed: -admitted : [DATE]; - Moderately impaired cognition; -Diagnoses included heart failure, muscle weakness, and diabetes. Review of the medical record on [DATE] and [DATE], showed a signed full code status form, dated [DATE]. Review of the POS, dated ,d+[DATE], showed the selection of full code. 8. Review of Resident #41's, medical record, showed: -admitted : [DATE]; -Cognitively Intact; -Diagnoses included bipolar disorder (disorder associated with mood swings ranging from depressive lows to manic highs), diabetes and depression. Review of the medical record on [DATE], and [DATE], showed a signed full code status form, dated [DATE]. Review of the POS, dated ,d+[DATE], showed the selection of full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During an observation and interview on [DATE] at 1:10 P.M., the SW removed and replaced multiple residents' outdated code status forms with updated, signed forms. She said multiple residents' charts needed to be updated. The updated forms should have been placed in the appropriate resident charts at the time of the updates. She had updated code status forms from [DATE] through [DATE] that she was now placing into the appropriate resident charts. 10. During an interview on [DATE] at 7:43 A.M., Certified Medication Technician (CMT) B said that the resident's code status could be found in the front of the resident's chart. 11. During an interview on [DATE] at 7:51 A.M., Licensed Practical Nurse (LPN) F said the Social Worker had the resident sign a code status sheet upon admission. The nurses and Director of Nursing (DON) obtain physician orders for code status. A resident's code status should be included on the POS, whether they are full code or do not resuscitate (DNR). The physician order should match the signed code status sheet. The Social Worker was responsible for updating the code status sheets. 12. During an interview on [DATE] at 8:15 A.M., LPN D said that the resident's code status could be in the front of the chart and on the POS. He/She treated every resident as a Full Code. 13. During an interview on [DATE] at 1:30 P.M., LPN E said each resident's code status should be updated yearly by the SW. If a resident was unresponsive, staff would access the chart and verify the code status. The POS should reflect an accurate code status. 14. During an interview on [DATE] at 3:05 P.M., the SW said she completes the admission paperwork for admitted residents. Upon admission, the code status is reviewed with the resident or the guardian, and signatures obtained. If a DNR is elected, the physician is notified and the physician will sign the selection. If full code is selected, the election gets copied and added to the chart. The SW updates code status annually. Multiple residents annual renewals were due in May and June, and she placed the updated forms into the medical records on [DATE]. Physician orders are obtained for code status. The nursing department was responsible for obtaining the updated physician orders for code status. Code status, regardless if cardiopulmonary resuscitation (CPR) or DNR, should be on the POS. If code status is not confirmed with a signature, the resident would default to a full code status. 15. During an interview on [DATE] at 10:25 A.M., the DON said the resident's code status was located on the face sheet, the POS and in the red binder containing the Activities of Daily Living (ADL) tool, which was indicated by the color of the dot on the bottom of the page. 16. During an interview with the DON and Administrator on [DATE] at 10:26 A.M., the DON said a resident's code status preference should be documented on their face sheet in the paper chart. In the paper chart, the resident's signed code status should be behind the resident's face sheet. A physician order should be obtained for the resident's code status, and the order should be included on the POS. The physician's order for code status should match what is on the signed code status sheet. The DON checked each resident's POS during monthly recapping to verify the resident's code status was on there, including whether the resident was full code or DNR. The Social Worker obtained a resident's code status upon admission. Code status sheets should be updated by the Social Worker annually.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49992 Based on observation, interview and record review, the facility failed to provide a homelike environment for one resident when staff failed to ensure the hot water faucet in the resident's was functioning properly (Resident #67). The sample was 18. The census was 79. Review of Resident #67 medical record, showed: -Diagnoses of depression, Alzheimer's disease, high blood pressure, high cholesterol, and mood disorder; -A Care Plan, dated 4/5/24, showed the resident can shower independently, requires only set up as needed. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/5/24, showed: -Cognitively is intact; -Requires setup or clean-up assistance with showering or bathing. Observation and interview on 6/24/24 at 9:17 A.M., showed the hot water faucet located in the resident's bathroom did not function properly, when turned on, no water was produced. The resident said he/she prefers to bath in the sink located in his/her room because of the time it takes the staff to get him/her to the shower room. He/She has told the nurses about the hot water faucet. Observations on 6/25/24 at 9:30 A.M., and 6/26/24 at 6:37 A.M., showed the hot water faucet located in the resident's bathroom did not function properly, when turned on, no water was produced. During an interview on 6/27/24 at 7:47 A.M., Certified Nursing Assistant (CNA) A said if the resident reports that something is broken, he/she would tell the charge nurse, and there are paper slips located on the maintenance door on the 300 floor that can be filled out to make them aware that something needs to be fixed. Once the slips are completed, there is a box the staff can leave the requests. He/She was unaware that the hot water faucet in the resident's room was not working. During an interview on 6/27/24 at 7:58 A.M., Maintenance C said he/she was unaware that the hot water faucet in the resident's room was not working. The staff are aware that there are paper slips located on his/her door that identify items that need repair, the staff put the completed slips in the box on the door. He/She checks the box regularly. During an interview on 6/27/24 at 8:15 A.M., Licensed Practical Nurse (LPN) D said he/she was unaware that the hot water faucet was not working in the resident's room. If there is something that needs to be repaired, he/she would go to the 3rd floor, and on the maintenance door there are slips that can be filled out and he/she would put them in the box on the door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator and Director of Nursing on 6/27/24 at 10:35 A.M., both were unaware that the hot water faucet was not working properly in the resident's. The Administrator said when the staff need to notify maintenance for a broken item, there are paper slips and a box on the maintenance door that the staff can complete.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to implement and document a discharge planning process involving the legal guardian for one resident (Resident #36) with an expressed interest in transitioning to a placement with a lower level of care. The sample was 18. The census was 79. Review of the facility's Discharge Summary and Plan policy, revised October 2022, showed: -Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan; -The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family; -The discharge plan is re-evaluated based on changes in the resident's condition or needs prior to discharge; -The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan; -Residents are asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, he or she will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences; -If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the determination. Review of Resident #36's medical record, showed: -admitted [DATE]; -Public administrator appointed the resident's legal guardian; -Diagnoses included polyneuropathy (peripheral nerve disorder), depression, anxiety, insomnia, bipolar disorder, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and alcohol disease. Review of the resident's Level I Preadmission Screening and Resident Review (PASRR), a federally mandated screening process for individuals with serious mental illness and/or intellectual disability who apply or reside in Medicaid-certified beds in a nursing facility, signed by the physician 12/20/23, showed: -Resident with current, suspected, or history of major mental illness; (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Identify what services/supports may be needed to live successfully in a less restrictive environment: community-based psychiatric treatment and supports, 12-step/substance abuse program, medical follow-up/physician services (requires ongoing medical and psychiatric follow-up to promote stability), medication education/counseling/set-up and administration, residential services/supported housing, Social Work services/case management, nutritional/dietary evaluation. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/28/23, showed: -Cognitively intact; -Behaviors, rejection of care, and wandering not exhibited; -Set up assistance required for eating and bathing; -Independent with oral hygiene, toileting, dressing, and mobility. Review of the resident's Level II PASRR summary of findings, dated 1/18/24, showed: -Needs at this time can be met in nursing facility; -Does not need specialized services beyond those typically available in a nursing facility; -The following services and supports are to be provided by the nursing facility: Medication therapy, personal support network, structured environment, discharge planning. Review of the resident's care plan, revised 3/27/24, in use at the time of survey, showed: -Resident was previously at another nursing facility that abruptly closed down. Resident is alert and oriented times 3 to 4 (to person, place, time, and situation) and is able to express his/her thoughts and needs. Resident has a court appointed guardian to make decisions; -No documentation of guardian in attendance of care plan meetings; -No documentation related to discharge planning or the resident's desire to reside in a less restrictive placement. Further review of the resident's medical record, showed no documentation of communication with the resident's legal guardian regarding discharge planning and whether or not it would be feasible for the resident to transition to a setting in which a lower level of care was provided. (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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Home	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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/24/24 at 10:28 A.M., the resident said his/her family member was his/her legal guardian until the family member experienced a change in mental status and a Public Administrator became appointed to take the family member's place. The resident had a psychiatric inpatient hospitalization and upon discharge, his/her Public Administrator/legal guardian had the resident transferred to a skilled nursing facility. The resident was in the other nursing facility from 2019 until it abruptly closed in December 2023. Throughout his/her stay in the previous facility and his/her current facility, he/she has not had any behavioral issues. He/she has not experienced any exacerbated symptoms of his/her mental health diagnoses. He/She does not require any assistance from staff, aside from medication administration. He/She knows how to schedule doctor appointments, fill prescriptions, arrange for transportation, and manage finances. He/She feels locked up in the facility, like he/she is in prison. He/She has not been involved in any conversation with the facility or with his/her guardian regarding discharge planning since being admitted to the facility. During an interview on 6/24/24 at 12:12 P.M., Licensed Practical Nurse (LPN) E said he/she knew the resident from his/her stay at the nursing facility from which he/she was admitted in December 2023. During his/her stay at the previous facility and throughout his/her stay this facility, the resident has not exhibited any issues or aggressive or problematic behaviors. During an interview on 6/25/24 at 8:35 A.M., the resident said he/she has not been involved in a care plan meeting since admission to the facility. Last year, he/she talked to his/her legal guardian about his/her desire to live independently and the guardian instructed him/her to attend 12-step recovery meetings over the summer of 2023. The resident attended meetings as instructed and has not heard from the guardian about next steps. He/She has not worked with any outside entity to receive support services that would assist him/her in obtaining skills or resources to be able to reside in a less restrictive environment. He/She has spoken to the facility's Social Worker (SW) about his/her desire to live in a setting with a lower level of care, and the SW said she cannot get a hold of the resident's guardian. During an interview on 6/25/24 at 3:05 P.M., the Social Services Director (SSD) said the resident sees a psychiatrist regularly, and the psychiatrist is evaluating the resident for his/her ability to live independently. The psychiatrist thinks the resident is stable and it is unknown how long the psychiatrist will continue the evaluation. The resident is stable and he/she is independent with his/her activities of daily living. He/She is compliant with taking his/her medications and keeps to him/herself. He/She paces up and down the hallway, but does not exhibit any other behaviors. If discharged , he/she might need assistance with medication management. The resident's guardian has not seen the resident since he/she was admitted to the facility. The resident's guardian does not call to check on the resident and he/she did not participate in the resident's care plan meeting. The SSD has reached out to the resident's guardian regarding money for clothing and scheduling appointments for the resident to see specialists. They have not had conversations regarding discharge planning. It is very difficult to get verbal or emailed responses from the resident's legal guardian. (continued on next page)

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Carrie Elligson Gietner Home	5000 South Broadway Saint Louis, MO 63111

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 9:23 A.M., the Administrator said the resident's legal guardian is a Public Administrator in another county. It is difficult for facility staff to get through to the resident's legal guardian. When the resident came to the facility in December 2023, they received very little information about him/her from the previous facility. They know the resident was appointed a legal guardian due to psychiatric issues, but the guardian did not provide the resident with much information either. The resident has been very compliant in taking his/her medications and he/she understands he/she needs them. He/She has not exhibited any behaviors since admission to the facility. He/She is very high functioning and does everything for him/herself, except he/she does depend on facility staff for medication management and administration. Due to his/her payer source and other factors, he/she might not meet the criteria to qualify for support services provided by outside entities, which would also require the legal guardian's consent. The Administrator has attempted to call the resident's legal guardian a couple of times with no success getting through. She has not documented the attempted communication. She was not aware the SSD has not documented her attempted communication with the legal guardian and would expect her to do so. Discharge planning is discussed during quarterly care plan meetings and discharge planning should be documented.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 Based on observation, interview and record review, the facility failed to ensure five residents who required assistance with activities of daily living (ADL) received personal care, nail care, and facial hair hygiene in accordance with their needs and preferences (Residents #2, #19, #20, #7 and #17). The sample was 18. The census was 79. Review of the facility's undated perineal (area including and between the genitals, hips and anal area) care policy, showed: -Purpose: to provide cleanliness and comfort to the resident, to prevent infection, skin irritation and observe the skin condition; -Steps in the procedure: -Wash perineal area, cleaning front to back; -Separate the skin continuing to cleanse in a front to back motion; -Move from inside outward to the thighs. Rinse the skin in a same manner; -Clean the rectal area, front to back of the buttocks. Rinse and dry thoroughly. Review of the facility's undated ADL policy, showed: -Statement: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene; -Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident, in accordance with the plan of care, including appropriate support and assistance with hygiene, such as bathing, dressing, grooming and oral care. 1. Review of Resident #2's quarterly Minimum Data Set (MDS, a federally required assessment instrument completed by facility staff), dated 4/24/24, showed: -Severe cognitive impairment; -Unable to make needs and wants clearly known; -Diagnoses included falls, dementia, skin cancer, kidney failure, and high blood pressure. Review of the resident's care plan, showed: -Problem: self-care deficit; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goals: maintain current level of function, will be clean and well groomed; -Interventions: frequently incontinent of bowel and bladder, staff provide full assistance with hygiene. Observations of the resident, showed: -On 6/24/24 at 1:00 P.M., the resident sat in his/her wheelchair in the unit lobby. Long facial hair noted to the chin, upper and lower lip. Dark debris under all fingernails. He/She wore a stained pink shirt, food noted on his/her gray pants; -On 6/25/24 at 8:18 A.M., the resident sat in his/her wheelchair in the unit lobby. Long facial hair noted to chin, upper and lower lip. Dark debris under all fingernails. The resident wore the same clothing from 6/24/24; During an observation and interview on 6/25/24 and 1:06 P.M., Certified Nurse Aides (CNA) A and G transferred the resident into the bed. Care was explained to the resident. Staff applied gloves and removed the soiled brief. CNA A obtained wet wipes and cleansed the front of the groin. CNA G assisted the resident onto his/her side and exposed the buttocks. A large area of feces between the buttocks. CNA A used three wet wipes to clean the skin. CNA A removed his/her gloves, applied clean gloves, and applied a clean brief under the resident. CNA A lifted the left buttock to expose the skin for assessment. A large area of loose stool remained between the buttocks. CNA A did not provide additional needed cleansing to the buttocks. CNA A and CNA G applied and secured the clean brief to the resident, applied clean clothing, and assisted him/her into the wheelchair. CNA G said he/she would shave the resident and added the resident does not like the long facial hair. CNA A said staff should provide facial shaving when weekly showers are given, nails should be trimmed. Nail cleaning should be done daily. 2. Review of Resident #19's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; -No behaviors, does not resist care; -Paralysis to both sides of the body; -Dependent on staff for care needs; -Diagnoses included weakness, fall history, diabetes, and traumatic head injury. Review of the resident's care plan, updated 5/24/24, showed: -Problem: self-care deficit; -Goals: will be clean and well groomed; -Interventions: staff provide assistance with daily hygiene and personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 6/24/24 at 11:28 A.M. and 1:32 P.M., and on 6/25/24 at 6:58 A.M., 9:02 A.M., and at 12:11 P.M., showed the resident had long nails and dark debris under all fingernails. 3. Review of Resident #20's medical record, showed: -Diagnoses included anxiety, Alzheimer's disease, high cholesterol, depression, and mood disorder; -Ambulates with a cane. Review of the resident's care plan, dated 4/18/24, showed: -Potential for self-care deficit related to dementia, Alzheimer's disease, psychiatric issues, and pain; -Goal: The resident will maintain current level of function and be clean and well-groomed thru next review; -Interventions: Personal care done independently, assist as needed, set up/cueing or supervision required; -Showers assist, set up as needed with showers. Staff will usually shave and cut resident's hair. Resident frequently refuses to showers, grooming, and to change clothing. The resident will become agitated, yell, and curse staff attempting to help. Staff to encourage good hygiene, approach when behavior subsides. Observation and interview on 6/24/24 at 9:49 A.M., showed the resident in his/her room. Soiled clothes lay on the floor and a brown granule substance near the bed on the floor. A collection of used napkins, and a sticky clear substance on the over-the-bed table. The resident wore a fleece type button up jacket, heavily soiled with a brown substance. The resident's fingernails jagged, discolored and with a brown substance under the longer nails. The resident's hair un-brushed and oily in appearance. The resident said he/she gets showers and that he/she does not need help from the staff. Observation on 6/25/24 at 12:31 P.M., showed the resident in the dining room, he/she brought his/her water pitcher from his/her room, which had a used, soiled napkin sitting on top. The resident wore the same clothes from the day before. Nails still jagged with a brown substance under the longer nails. Hair pulled back and appeared oily. Observation on 6/26/24 at 7:50 A.M., showed the resident arrived in the dining room with clean clothes, nails not trimmed or cleaned, and hair appeared oily. 4. Review of Resident #7's medical record, showed: -Diagnoses included dementia, seizure disorder, paranoia, alcoholism, chronic obstructive pulmonary disease (lung disease), and schizophrenia (mental illness that affects a person's thoughts, feelings, and behaviors); -Up adlib (resident can move around freely). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, dated 6/12/24, showed: -Potential for self-care deficit related to dementia; -Goal: The resident will maintain current level of function and be clean and well-groomed thru next review; -Interventions: Personal care done independently, set up/cueing or supervision required; -Showers independently, set up as needed with showers; staff will usually shave and cut resident's hair. Observation on 6/24/24 at 11:30 A.M., showed the resident in the hallway, walking towards the nursing station. The resident's t-shirt and jacket heavily stained with varying-colored dried spills and the jeans had brown dried stains near the zipper and pockets. There was a dark brown substance under the residents' fingernails on both hands. Observation on 6/25/24 at 9:27 A.M., showed the resident in the hallway near the 2nd floor nurse's station. The resident wore the same t-shirt and jeans from the day before, and the dark substance under the fingernails still present. Observation on 6/26/24 at 6:35 A.M., showed the resident waited outside of dining room doors. The resident wore the same t-shirt and jeans for the 3rd day. The resident's hands in his/her pockets of the jacket. Observed on 6/26/24 at 7:50 A.M., showed the resident ate breakfast and used his/her fingers to lift food items. A dark brown substance remained under his/her fingernails. 5. Review of Resident #17's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Diagnoses included schizophrenia and depression; -Requires supervision and verbal cues with hygiene. Observations on 6/24/24 at 10:38 A.M. and on 6/25/24 at 2:46 P.M. showed the resident had long facial hair on his/her chin and neck. During an interview on 6/26/24 at 12:12 P.M., the resident said he/she does not like facial hair, he/she needed staff to remove the facial hair. 6. During an interview on 6/27/24 at 7:47 A.M., CNA A said that residents receive two to three showers a week. During the shower, staff provide assistance with bathing and will shave male residents if needed. Staff will clean the fingers nails of residents who need assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. During an interview on 6/27/24 at 7:56 A.M., Certified Medication Technician (CMT) B said all nursing staff are expected to assist the residents with ADL care including removal of facial hair. He/She would expect resident preferences of facial hair to be care planned. 8. During an interview on 6/27/24 at 8:15 A.M., Licensed Practical Nurse (LPN) D said the residents receive two to three showers a week. The staff should provide assistance if needed, shave, shampoo, and clean fingernails. 9. During an interview on 6/27/24 at 10:25 A.M., the Director of Nursing (DON) said that staff should be cleaning the resident's fingernails while in the shower and assist with shaving facial hair. She expects staff to assist the residents with changing their clothing if there are stains. 46888 49992

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 Based on observation, interview and record review, the facility failed to ensure neurological assessments were completed and documented for two of two sampled residents who experienced falls (Residents #42 and #79). The facility also failed to secure and lock the 200 unit medication cart. The sample was 18. The census was 79. 1. Review of the facility's undated fall policy, showed: -The nurse should assess and document and report vital signs, injury especially if a head injury, changes in range of motion, change in cognition or level of consciousness, neurological status, pain, frequency and number of falls since the last physician visit, factors on how the fall occurred, all medications and active diagnoses; -The staff will evaluate and document falls that occur while the individual is at the facility, for example when and where the fall happens, observations of the events; -Falls should be identified as witnessed or unwitnessed; -Monitoring and follow-up: -The staff, with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as a fracture of subdural hematoma (brain bleed) have been ruled out or resolved; -Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. During an interview on 6/27/24 at 10:15 A.M., the Director of Nursing (DON) said anytime a resident experienced an unwitnessed fall or a fall that resulted in a head injury, staff are expected to implement the neurological assessment for 72 hours. The neurological assessment is used to detect changes in brain function. The assessment also should include frequent vital signs. Staff notify her when a resident falls and begin the fall investigation. If the neurological assessment form is not available, the nurses should document a detailed assessment in the nurse notes. 2. Review of Resident #79's admission Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 2/5/24, showed: -Moderate cognitive impairment; -No behaviors, does not resist care; -Needs substantial to moderate staff assistance for care needs; (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included diabetes, dementia, stroke and paralysis; -No fall history. Review of the resident's fall risk assessment, dated 1/29/24, showed: -Level of consciousness/mental status: intermittent confusion; -History of falls, past 3 months: 0; -Ambulation/elimination status: chair bound; -Vision status: adequate; -Medications: takes one to two medications that could affect gait/stability; -Predisposing diseases: one to two present; -Total score: 13, high risk. Review of the resident's care plan, dated 2/5/24, showed: -Problem: potential for falling; -Goals: remain free from falls; -Interventions: requires one to two staff for transfers, lock the wheelchair, encourage call light use, maintain bed in locked position. Review of the resident's nurse's notes, showed: -On 3/19/24 no time documented: nurse called to resident's room by therapy. The resident noted sitting on the floor and his/her back against the floor. Neurological checks initiated . Physician notified; -On 4/2/24 at 6:45 A.M., during rounds the resident found on the floor wrapped in a blanket. The resident was assessed and a bruise found on the right cheek. At 8:10 A.M., physician notified and agreed with policy to initiate neurological checks; -No documented neurological checks found in the nurse's notes for the falls on 3/19/24 and 4/2/24. 3. Review of Resident #42's quarterly MDS, dated [DATE], showed: -Able to make needs and wants known; -No behaviors; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included heart disease, high blood pressure, vascular disease, stroke, dementia, anxiety and depression; -No fall history. Review of the resident's nurse note's, showed: -On 6/24/24 at 10:30 A.M., resident noted lying on his/her right side, the resident stated he/she hit his/her head. Noted a 1.3 centimeter (cm) laceration to the right forehead with bleeding noted. Wound cleaned and steri-strips applied. Able to move extremities and refused transfer to the emergency room ; -On 6/25/24, no time documented: the resident said he/she fell asleep in the wheelchair and he/she slid out of the wheelchair. He/She normally gets in bed to sleep but stayed up later than normal and dosed off. The resident said he/she will attempt to place his/her wheelchair next to the bed and he/she can lean over and sleep on the bed; -No documented neurological checks found in the nurse's notes for the fall on 6/24/24. Review of the resident's care plan, updated 6/24/24, showed: -Problem: found on floor, feel asleep in the wheelchair. Received laceration to forehead and left foot. Has a right above the knee amputation; -Goal: remain free from injury; -Intervention: encourage to take naps in the bed, and the resident stated he/she would try. Staff encourage resident to allow assistance when needed. Use call light and encourage rest periods; -No documentation regarding neurological assessments post fall with head injury. During an interview on 6/25/24 at 12:08 P.M., the resident said he/she had a fall out of his/her wheelchair on 6/24/24 between 7:00 A.M. and 7:15 A.M., he/she bled from his/her forehead. He/she fell asleep in the wheelchair and fell forward. He/She struck his/her head on the floor. He/She yelled for help and about 30 minutes later, when staff delivered the breakfast tray, he/she got help. Staff had not checked or completed frequent vital signs. The nurse applied a bandage to the cut on his/her forehead. During an interview on 6/27/24 at 8:14 A.M., Licensed Practical Nurse (LPN) E said if a resident experienced an unwitnessed fall, staff should conduct a neurological assessment. The neurological assessments should be kept at the nurse's station. He/She had worked with the resident as the charge nurse the last several days. He/She did not have access to the neurological assessment form. If the form is not available, the nurse should document in the nurse notes. He/She had not conducted the neurological assessments. LPN E added he/she had conducted vital signs each shift. Neurological assessments are done for 72 hours. If the resident refuses neurological assessments, that refusal should be documented in the record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 8:22 A.M., the resident said after the fall, the nurses came and got his/her blood pressure once a day. 4. Review of the facility's undated Medication Labeling and Storage Policy, showed: -Policy Statement: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys; -Policy Interpretation and Implementation Standard: Medication Storage-Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and tray or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Observation on 6/26/24 at 6:41 A.M., showed the medication cart on the 2nd floor unlocked, with the medication administration record (MAR) binder left on top with the keys to access the cart, with no staff in close proximity. At 6:55 A.M., a vendor filling the food vending machine in close proximity to the unsecured cart and a resident walked up to the medication cart, placing his/her hand on the cart to balance himself/herself while sitting on the windowsill. Several staff members walked to the nurse's station, near the medication cart and did not secure the cart. At 7:05 A.M., Certified Medication Technician (CMT) B approached the cart, noted that the cart was unsecured and locked the cart. During an interview on 6/27/24 at 7:43 A.M., CMT B said that the medication carts should be locked when not in use and the keys should not be left unattended. During an interview on 6/27/24 at 8:15 A.M., LPN D said that medication carts should not be left unlocked when staff are not using the carts. The person responsible for the cart should secure the keys. During an interview on 6/27/24 at 10:25 A.M., the DON said that the medications carts should be locked when not in use. The keys should never be left unattended.

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37672 Based on observation, interview and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status to the extent possible, for one resident (Resident #34) who experienced a significant weight loss of 20 pounds from a weight on 5/14/24 of 136.6 pounds to 116.0 pounds on 6/26/24, resulting in a 15% weight loss in 6 weeks. During this timeframe, the facility's Registered Dietician (RD) completed a nutritional assessment and recommended health shakes three times a day. Staff failed to provide the supplements as ordered. The sample was 18. The census was 79. Review of the facility's undated nutrition/unplanned weight loss policy, showed: -Assessment and recognition: -Nursing staff will monitor and document the weight and dietary intake of residents; -The staff and physician will define the individuals current nutritional status and identify individuals with weight loss and at risk for significant impaired nutrition; -The staff will report to the physician significant weight loss or gain or any abrupt or persistent change from baseline appetite or food intake; -Treatment/management: -The staff and physician will identify pertinent interventions based on causes and resident condition, prognosis, and wishes; -Treatment decisions should consider all pertinent evidence and relevant issues and not based solely on laboratory test results; -The physician will authorize appropriate interventions; -The staff and physician will review and consider existing dietary restrictions and modified consistency diets; -Monitoring: -The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions; -When medical conditions or medication related adverse consequences are causing or contributing to altered nutritional status, the physician and staff will collaborate in adjusting interventions, taking into account the status of those causes and the resident's responses, goals, wishes, prognosis, and complications; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The physician and staff will collaborate to address any issues related to weight and nutrition related to severe or prolonged impairment of nutritional status and weight loss. Review of Resident #25's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/29/24, showed: -Moderate cognitive impairment; -Verbal behaviors toward staff; -Staff provide partial to moderate assistance with meals; -No swallowing disorders; -Weight: 131 pounds; -Loss or gain of 5 percent to 10 % in the last six months: no or unknown; -Mechanically altered diet; -Diagnoses included schizophrenia, Parkinson's disease, respiratory failure, and irregular heartbeat. Review of the resident's care plan, updated 4/29/24, showed: -Problem: potential for weight loss/gain; -Goals: April weight: 131; -Interventions: regular diet, health shakes three times a day. Staff provide dietary supplements and health shakes as ordered, staff provide meal set up in the resident's room, monitor the resident's meal intake and offer substitute for uneaten foods. Monitor weights monthly and notify the physician of a weight loss or gain of five pounds. Review of the resident's monthly weight tracking form for 2024, showed: -January: 137 -February: 132.8 -March: 133.7 -April: blank Review of the resident's hospital summary, dated 4/11/24, showed: -Reason for hospitalization : altered mental status; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Additional instructions: risk for malnutrition; -Signs: unplanned weight loss, loss of appetite, lack of food interest, tiredness and low energy, changes in mood or concentration; -Instructions: nutritional supplement liquid, such as high calorie, high protein supplement two to three times a day and continue for 30 days after discharge. Review of the resident's monthly weight tracking form, showed May 2024 blank, no documented weight. Review of the resident's dietary history and screening form, dated 5/14/24, showed: -Weight: 136.6 pounds; -Weight is stable; -Diet order: Regular; -Supplement orders: bedtime and three times a day; -Meal consumption average: 50-75%; -Multiple missing teeth; -Snack/supplement preferred: health shakes with meals, three times a day. Review of the resident's June 2024, physician order sheet, showed: -Diet: regular; -Patient care: health shakes three times a day. Review of the resident's monthly weight tracking form, showed June 2024 weight of 102.0 pounds. Observation and interview on 6/24/24 at 9:08 A.M., showed the resident in his/her room in his/her wheelchair. The resident appeared thin. A breakfast plate noted on the over bed table. The breakfast plate covered. The resident said he/she was not very hungry and did not want what was on the plate. Staff did not offer to cut his/her sausage or toast. No health shake noted on the tray. The morning meal dietary ticket did not reflect health shakes with meals. Observation on 6/25/24 at 8:52 A.M., showed the resident in his/her room. The breakfast tray did not contain a health shake supplement. The meal ticket showed regular diet and no ordered supplements noted on the meal ticket. Observation and interview on 6/25/24 at 12:19 P.M., showed the resident in his/her room. The noon meal tray sat on the over the bed table. The resident had consumed approximately 25% of the meal. No health shake supplement noted. The resident said he/she had not been offered shakes with meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/24 at 1:43 P.M., Licensed Practical Nurse (LPN) E said the resident can have behaviors at times and prefers to eat in his/her room. Staff should monitor and notify the charge nurse if the resident is noted to have a decreased appetite or is not eating much. When the dietician provides a recommendation, the nurse should notify the physician and write the order into the chart. A dietary form is also filled out and taken to the kitchen. The meal ticket should reflect the dietary orders and include supplements. The supplemental health shakes are placed on the tray by the kitchen staff. Staff should review the meal ticket before serving the resident for accuracy. Observation interview on 6/26/24 at 12:06 P.M., showed the resident in his/her room. The resident did not eat the lunch meal of pasta, chicken, or mixed vegetables. The resident said he/she told the staff he/she did not want the served food when the lunch tray was delivered to his/her room. Staff did not offer an alternative meal. The resident said he/she was hungry and requested ice cream. Observation on 6/26/24 at 12:32 P.M., showed the resident in his/her room eating ice cream, no additional food noted. During an interview on 6/26/24 at 1:08 P.M., the Director of Nursing (DON) said the resident got weighed in his/her wheelchair. The resident refused to transfer out of the wheelchair for staff to obtain the wheelchair weight, so staff would weigh the wheelchair when the resident went to bed to deduct the weight of the wheelchair. During an interview on 6/27/24 at 10:33 A.M., CNA A said the aides pass the trays to the residents. The kitchen puts the meal tickets on each resident tray. If a resident has supplements on the meal ticket, the supplements are sent with the meal trays. He/She does not know how the meal order is changed. The aides are supposed to check the meal ticket before giving the resident the food. He/She worked yesterday day shift and gave the resident his/her meal trays. Neither of the meal trays had a supplement included. The resident appeared thin and he/she slept frequently. The resident also needs help with food to be cut up, but if the resident is sleeping, CNA A would try to remember to return to the room but he/she had forgotten. During an interview on 6/27/24 at 7:02 A.M., the Administrator said when the resident went to bed, staff obtained the wheelchair weight. The resident's weight after deducting the wheelchair was 116 pounds. When staff compared the current weight to the hospital weight in May, the resident has experienced around a 20 pound weight loss. When staff reviewed previous orders, the resident should have received health shakes with meals. In addition, the facility is going to add double portions. When the dietician makes recommendations, the charge nurse is responsible to notify the physician and write the order onto the physician order sheet. The nurse also fills out the dietary order sheet and notifies the kitchen of the change. Health shakes are provided by the kitchen. The supplement should be noted on each meal ticket. The registered dietician and physician should be notified when weight loss is noted. Physician and registered dietician recommendations should be followed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49992 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when one resident (Resident #51) was not administered the ordered dose of Lasix (diuretic) for over two weeks. The sample was 18. The census was 79. Review of the facility's undated Medication Orders policy, showed: -The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders; -When recording orders for medications, specify the type, route, dosage, frequency, and strength of the medication ordered. Review of the facility's undated Administering Medications policy, showed: -Medication are administered in a safe and timely manner, and as prescribed; -Medications are administered in accordance with prescriber orders, including any required time frame. Review of Resident #51's medical record, showed: -Diagnoses included high blood pressure, diabetes, anxiety, high cholesterol, and pain; -An order, dated 6/10/24, for Lasix 20 milligrams (mg) by mouth daily for seven days. Obtain blood pressure for seven days, if measures below 100/50 do not give Lasix. Diagnosis of lower extremity edema (swelling). Review of the Resident's medication administration record (MAR) for June 2024, showed no entry for the Lasix or the resident's blood pressure. During an interview on 6/27/24 at 8:15 A.M., Licensed Practical Nurse (LPN) D said when an order is written or verbally given by the physician, the nurse transcribes the order to the MAR as written or verbally given by the physician. For an order that would only be for a certain time period, the nurse would block out the days on the MAR. For an order that would require parameters, the nurse would transcribe the order as written. During an interview on 6/27/24 at 10:25 A.M., the Director of Nursing (DON) said she would expect the nurse to transcribe the order as written on the physician's order sheet (POS) to the MAR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46888 Based on observation, interview and record review, the facility failed to ensure food was prepared separate from dish cleaning and failed to ensure floors and walls in the kitchen were clean and free from debris, fans in the dish washing room free from dust build up, ceiling lights above the food prep station free from dust accumulation, and that the dry food storage rack was free from debris. The census was 79. Review of the facility's dietary cleaning duties, undated, showed: -Morning crew: mop kitchen and dining room, wipe down all racks, fridges, and freezers; -Evening crew: mop kitchen; -Weekly: dietary supervisor to clean all equipment that may emit dust, lint, or grease residue in the kitchen, dining room, dishwasher room, and all dietary storage areas. 1. Observation of lunch preparation on 6/25/24, showed: -At 8:52 A.M., the Dietary Supervisor opened bags of raw chicken and placed chicken into the sink; -At 8:55 A.M., [NAME] H brought two pans over to the sink next to where the chicken was and started to clean the dishes; -At 8:56 A.M., water from the sink where dishes were being cleaned was observed to splash over to the sink holding the raw chicken as [NAME] H cleaned the dishes. 2. Observations on 6/24/24 at 9:09 A.M. and on 6/25/24 at 9:00 A.M., showed: -The floor, baseboards, and wall under and around the sink area in the main kitchen were caked with various substances and food debris; -The floor, baseboards, and wall under the cereal/toaster station were caked with various substances and food debris; -The baseboards and wall around the oven and deep fryer were caked with sticky grease and various substances. 3. Observations on 6/25/24 at 9:37 A.M. and on 6/26/24 at 7:01 A.M., showed two fans in the dish washing room covered with thick dust accumulation. Both fans were observed to be positioned to blow on clean dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Observation on 6/25/24 at 8:28 A.M. showed the light fixture above the food preparation table with dust build up with dust hanging from the light. Left over breakfast food observed to be uncovered on the meal preparation table and on 6/27/24 at 7:17 A.M., observation showed the light fixture above the food preparation table to have dust accumulation and build up. 5. Observations on 6/24/24 at 9:15 A.M., 6/25/24 at 8:47 A.M., and 6/26/24 at 9:51 A.M., showed the dry storage rack in the back of the dry storage room with a white powder spill. The white powder was in various areas on the rack. 6. During an interview on 6/27/24 at 7:18 A.M., [NAME] H said all kitchen staff are responsible for cleaning floors and that the kitchen is cleaned weekly. He/She would expect the kitchen to be clean. He/She would expect food to be prepped away from dish washing areas to avoid contamination. 7. During an interview on 6/27/24 at 7:58 A.M., the Dietary Supervisor said all kitchen staff are responsible for cleaning the kitchen and storage areas. He would expect the kitchen to be clean and sanitary. He would expect for food to be prepared separate from dish washing. 8. During an interview on 6/27/24 at 10:56 A.M., the Administrator said she would expect for the kitchen and storage areas to be clean. All kitchen staff are responsible for cleaning the kitchen and storage areas and the manager is responsible for cleaning fans. She would expect food to be prepared separate from dish washing areas.

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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** 40290 49992 Based on interview and record review, the facility failed to ensure that in accordance with acceptable professional standards and practices, medical records were complete and accurately documented including the administration of medications and treatments for five residents (Resident #50, #20, #67, #7, and #51). The sample was 18. The census was 79. Review of the facility's undated Administering Medication Policy, showed: -Policy statement: medications shall be administered in a safe and timely manner, and as prescribed; -Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so; -The Director of Nursing (DON) Services will supervise and direct all nursing personnel who administer medications and/or have related functions; -The individual administering the medication must initial the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones; -If a dug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose; -As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: the signature and title of the person administering the drug. 1. Review of Resident #50's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 4/23/24, showed: -Cognitively intact; -Diagnoses included: heart failure, high blood pressure, kidney disease, diabetes, and high cholesterol. Review of the resident's physician order sheet (POS), dated 6/1/24 through 6/30/24, showed: -An order dated 3/11/20, for hydralazine (treats blood pressure) 100 milligram (mg) three times daily; -An order dated 3/11/20, for atorvastatin (treat high cholesterol) 40 mg once daily 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	-An order dated 3/17/20, for docusate (treat occasional constipation) 100 mg once daily at bedtime; -An order dated 11/23/23 for accu-check (checks blood sugar level) twice weekly, in the A.M., on Monday and Friday. Review of the resident's MAR, dated 4/1/24 through 4/30/24, showed: -Staff failed to document they administered the accu-check 2 out of 9 opportunities, with no supporting documentation on the back of the MAR. Review of the resident's MAR, dated 5/1/24 through 5/31/24, showed: -Staff failed to document they administered hydralazine 2 out of 93 opportunities, with no supporting documentation on the back of the MAR. Review of the resident's MAR, dated 6/1/24 through 6/30/24, showed: -Staff failed to document they administered atorvastatin 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered docusate 1 out of 27 opportunities, with no supporting documentation on the back of the MAR. 2. Review of Resident #20's quarterly MDS dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included: coronary heart disease (hardening on the arterial walls), high blood pressure, kidney disease, diabetes, high cholesterol, depression and dementia. Review of the resident's POS, dated 6/1/24 through 6/30/24, showed: -An order dated 6/13/14, for furosemide (diuretic) 40 mg twice daily; -An order dated 6/13/14, for Senna Plus (stool softener) 8.6-50 mg twice daily; -An order dated 6/13/24, for citalopram (treat depression) 20 mg daily; -An order dated 8/29/16, for calcium antacid (treat indigestion) 50 mg daily; -An order dated 8/29/16, for calcium antacid (treat indigestion) 1000 mg daily at bedtime; -An order dated 9/4/21, for buspirone (to treat depression) 5 mg daily; -An order dated 2/19/22, for memantine (treats dementia) 10 mg daily; -An order dated 2/10/22, for amlodipine (to treat high blood pressure) 10 mg daily; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order dated 3/1/22, for olopatadine solution 2% (eye allergies) one drop both eyes daily; -An order dated 5/4/22, for potassium chloride solution 10 % (treat low potassium) 7.5 milliliters (ml)/10 milliequivalent (mEq) once daily on Monday, Wednesday, and Friday; -An order dated 7/21/23, for Tradjenta (treat blood sugar) 5 mg once daily. Review of the resident's MAR, dated 4/1/24 through 4/30/24, showed: -Staff failed to document they administered the memantine 1 out of 30 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered the potassium chloride solution 1 out of 13 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered the Tradjenta 2 out of 30 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered the furosemide 4 out of 30 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered Senna Plus 4 out of 30 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered calcium antacid 3 out of 30 opportunities, with no supporting documentation on the back of the MAR. Review of the resident's MAR, dated 5/1/24 through 5/31/24, showed: -Staff failed to document they administered potassium chloride 1 out of 30 opportunities, with no supporting documentation on the back of the MAR. Review of the resident's MAR, dated 6/1/24 through 6/30/24, showed: -Staff failed to document they administered citalopram 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered buspirone 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered amlodipine 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered memantine 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered olopatadine solution 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; (continued on next page)

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	265668	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrie Elligson Gietner Home	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's POS, dated 6/1/24 through 6/30/24, showed: -An order dated 5/20/19, for Xifaxan (to help the liver remove toxins from the blood) 550 mg twice daily; -An order dated 12/6/19, for benztropine (treat muscle spasms caused by other medications) 0.5 mg twice daily; -An order dated 2/21/20, for atorvastatin (treat high cholesterol) 40 mg daily at bedtime; -An order dated 5/23/24, for mirtazapine (appetite supplement) 30 mg daily at bedtime. Review of the resident's MAR, dated 5/1/24 through 5/31/24, showed: -Staff failed to document they administered the Xifaxan 2 out of 62 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered benztropine 4 out of 62 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered atorvastatin 1 out of 30 opportunities, with no supporting documentation on the back of the MAR. Review of the resident's MAR, dated 6/1/24 through 6/30/24, showed: -Staff failed to document they administered the atorvastatin 1 out of 27 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered the mirtazapine 1 out of 27 opportunities, with no supporting documentation on the back of the MAR. 5. Review of Resident #51's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Diagnoses included: heart failure, high blood pressure, irregular heartbeat, hepatitis, diabetes, high cholesterol, depression, schizophrenia (mental illness), and dementia. Review of the resident's POS, dated 6/1/24 through 6/30/24, showed: -An order dated 12/21/20, for aspirin 81 mg daily; -An order dated 12/21/20, for Eliquis (blood thinner) 5 mg every 12 hours; -An order dated 12/21/20, for atorvastatin (treat high cholesterol) 40 mg every evening; -An order dated 6/8/23, for olanzapine (to treat mental illness) 10 mg daily; (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	06/27/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order dated 6/10/24, for furosemide (diuretic) 20 mg and blood pressures daily for 7 days; Review of the resident's MAR, dated 4/1/24 through 4/30/24, showed: -Staff failed to document they administered the aspirin 2 out of 30 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered Eliquis 4 out of 60 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered atorvastatin 1 out of 30 opportunities, with no supporting documentation on the back of the MAR; -Staff failed to document they administered olanzapine 2 out of 30 opportunities, with no supporting documentation on the back of the MAR. Review of the resident's MAR, dated 6/1/24 through 6/30/24, showed: -Staff failed to document they administered furosemide and blood pressures for 7 out of 7 days, with no supporting documentation on the back of the MAR. 6. During an interview on 6/27/24 at 8:15 A.M., Licensed Practical Nurse (LPN) D said that when an order is written or given verbally by the doctor, the nurse should transcribe the order correctly on the MAR or the Treatment Administration Record (TAR). When the resident refuses the medication or is on a leave of absence and the nurse is unable to administer the medications the nurse should circle their initials and put the reason on the back of the MAR or TAR. The doctor should be notified of the medications that were missed and this should be documented in the nurse's notes. 7. During an interview on 6/27/24 at 10:25 A.M., the Director of Nursing said that the nurses should transcribe the written orders or verbal orders as given onto the MAR and TAR. The nurses should notify the doctor if medications are missed, and they should make a note in the resident's chart.