

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>30687</p> <p>Based on observation, interview and record review, the facility failed to provide and maintain complete and accurate accounting records, regarding the reconciliation of petty cash kept on hand, for the resident trust account. The census was 144.</p> <p>Review of the facility's Resident Trust Policy, dated 2/2/24, showed the following:</p> <p>-Purpose: Complete Procedures on Resident Trust Responsibilities;</p> <p>-Resident Trust Petty Cash:</p> <p>-The facility will maintain a Resident petty cash fund for resident trust transactions only. The Petty Cash Clerk will be a facility employee designated by the Administrator at each facility. The Petty Cash Clerk will be someone other than the Resident Trust Clerk and the Administrator and will not be authorized to sign checks. On a daily basis usually at the end of the day, the Resident Trust Clerk must enter into the banking system all transactions into and out of the petty cash box;</p> <p>-Sign and date the form and obtain the Administrator's signature on the form to confirm that he/she has approved the reconciliation.</p> <p>Review of the bank statements for the resident trust on 6/25/24 at 9:38 A.M., showed the facility provided 11 reconciled bank statements which covered June 2023 through April 2024. The monthly reconciled bank statements did not include the reconciliation of the petty cash kept on hand. The petty cash reconciliation sheets were provided at 12:05 P.M.</p> <p>During an interview on 6/25/24 at 10:59 A.M., the Activity Director (AD) said he/she hands out money to the residents. The AD gets a report of the amount each resident has in their account to ensure they are able to withdraw money. The AD and the previous BOM reconciled the petty cash sheet and signed off on the sheet daily. The AD had not done a reconciliation sheet with the current BOM for about a month or so. The AD did not know why.</p> <p>Review of the facility's Resident Trust Petty Cash Reconciliation Forms, showed the following:</p> <p>-6/18/24:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cash given to activities: \$1500.00;</p> <p>-Cash returned from activities: \$1272.00 Signed by the BOM;</p> <p>-Cash on hand end of the day: \$1.00 bills: \$637.00;</p> <p>\$5.00 bills: \$635.00;</p> <p>-Disbursement: Beginning Receipt #: Blank. Ending Receipt #: Blank;</p> <p>-Total Disbursement \$228.00;</p> <p>-Total Cash on hand: \$1272.00;</p> <p>-Total Disbursements: \$228.00;</p> <p>-Total Cash Box Amount: \$1800.00;</p> <p>-Cash Balance From Start of Day: \$1500.00;</p> <p>-Reconciled by the BOM on 6/19/24.</p> <p>-6/19/21:</p> <p>-Cash given to activities: \$1800.00;</p> <p>-Cash returned from activities: \$1269.00 Sign by BOM;</p> <p>-Cash on hand end of the day: \$1.00 bills: \$624.00;</p> <p>\$5.00 bills: \$625.00;</p> <p>\$20.00 bills: \$20.00;</p> <p>-Disbursement: Beginning Receipt #: Blank. Ending Receipt #: Blank;</p> <p>-Total Disbursement \$231.00;</p> <p>-Total Cash on hand: \$1269.00;</p> <p>-Total Disbursements: \$231.00;</p> <p>-Total Cash Box Amount: \$1500.00;</p> <p>-Cash Balance From Start of Day: \$1500.00;</p> <p>-Reconciled by the BOM on 6/20/21.</p> <p>(continued on next page)</p>

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Reconciled by the BOM on 6/22/24.</p> <p>-6/24/24:</p> <p>-Cash given to activities: \$1500.00;</p> <p>-Cash returned from activities: \$896.00 Signed by the BOM and Human Resource Manager (HRM);</p> <p>-Cash on hand end of the day: \$1.00 bills: \$86.00;</p> <p>\$5.00 bills: \$800.00;</p> <p>\$10.00 bills: \$10.00;</p> <p>-Disbursement: Beginning Receipt #: Blank. Ending Receipt #: Blank;</p> <p>-Total Disbursement \$604.00;</p> <p>-Total Cash on hand: \$896.00;</p> <p>-Total Disbursements: \$604.00;</p> <p>-Total Cash Box Amount: \$1500.00;</p> <p>-Cash Balance From Start of Day: \$1500.00;</p> <p>-Reconciled by the BOM on 6/23/24.</p> <p>Observation and interview on 6/25/24 at 11:20 A.M., showed the HRM and the BOM count \$896.00 in the residents' petty cash box. The residents' petty cash box did not have a reconciliation sheet. The HRM said he/she did not know the starting balance of the petty cash box and did not have a reconciliation sheet. The BOM said the petty cash box is reconciled the next day to ensure the money is correct. The BOM said she had not reconciled the petty cash for today.</p> <p>During an interview on 6/25/24 at 1:00 P.M., the BOM said the start of the dollar amount \$1500.00 includes a check so the total will equal \$1500.00. The BOM said the check is not listed on the petty cash sheet but should be listed. The BOM said the cash box starts with \$1500.00. He/She must have written the wrong date and amounts in the petty cash forms for 6/19 and 6/20. The BOM could not provide a check for 6/19/24 and 6/20/24.</p> <p>During an interview on 6/25/24 at 1:05 P.M., the Assistant Administrator said he expected the petty cash to be reconciled in a timely manner with accurate dates and amounts.</p>		

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<p>F 0570</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure the security of all personal funds of residents deposited with the facility.</p> <p>30687</p> <p>Based on interview and record review, the facility failed to maintain an adequate surety bond for the resident trust fund account in the amount of one and one half times the average monthly balance for the past 11 months. The census was 144.</p> <p>Review of the facility's Resident Trust Policy, dated 2/2/24, showed the following:</p> <ul style="list-style-type: none"> -Purpose: Complete Procedures on Resident Trust Responsibilities; -General Information Regarding Responsibilities of Holding Resident Funds: <p>-The facility shall provide assurance of financial security by means of a surety bond. The bond shall be in an amount equal to at least one and one-half times the average total of the reconciled monthly balances. A copy of the current bond shall be kept in a file in the facility by the Resident Trust Clerk.</p> <p>Review of the bond report for approved facility bonds by the Department of Health and Senior Services (DHSS), showed an approved bond of \$175,000.00, dated 9/20/23.</p> <p>Review of the resident trust current balance report for April 2024, showed an amount of \$120,901.84 in the trust account.</p> <p>During an interview on 6/25/24 at 1:30 P.M., the Business Office Manager (BOM) and the Assistant Administrator said the surety bond was recently lowered by the corporate office. The BOM said they evaluate the bank reconciliation every August to see if it needs to be adjusted.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26002</p> <p>Based on observations of the residents' rooms and bathrooms and interviews with Residents #93 and #130, Houskeeper A and the Housekeeping Supervisor, the facility failed to provide a safe, clean, comfortable and homelike environment.</p> <p>An observation and interview with Resident #93 in his/her room on 6/20/24 at 10 a.m. revealed that his/her room (room [ROOM NUMBER]) and bathroom had not been cleaned thoroughly. Observation of the bathroom and his/her bedroom revealed the walls had brown stains, the floors were dirty, the commode in the bathroom had a brown substance around it's base and had stains on the floor and the walls and baseboard behind the commode. There was a dark brown substance on the vents of the exhaust fan above the commode.</p> <p>An observation of room [ROOM NUMBER], Resident #130's room on 6/21/24 at 10:03 a.m. revealed dark stained tile at the entrance to the resident's room, debris behind the bedroom door, debris under the air conditioning unit, water damaged grout stained brown behind the toilet tank, dark brown stained baseboards on the walls behind and beside the toilet, a trashcan with no liner and brown stains on the walls behind the trashcan, multiple hand towels without labels hanging in the bathroom on one (1) hook, multiple toothbrushes and toothpaste with no labels on the shared sink in the bathroom and no lid on the toilet.</p> <p>An interview on 6/20/24 at 12:29 p.m. with Housekeeper A for two (2) and six (6) halls revealed that he/she swept the floors, wiped down the fixtures, doorknobs, toilets and sinks. He/She stated they cleaned the breakroom, windowsills, headboards, light fixtures, rails in bathrooms and the mirrors. There were five (5) housekeepers who worked today.</p> <p>An interview on 6/21/24 at 10:37 a.m. with Licensed Practical Nurse (LPN) C revealed the facility did not have housekeeping staff for about six (6) months, and that the Housekeeping Department just started back up at the facility within the past two (2) months. When the facility did not have housekeeping, upper management put in place a trial program for department heads like Activities, Medical Records, and Administration to complete housekeeping duties for the facility. He/She said that the cleaning was not completed well, and that cleaning got better overall since they got housekeeping back. The LPN said that the cleanliness of the environment affected the residents' mood and their quality of life.</p> <p>Observations were made in the main dining room on 6/18/24 at 12:30 p.m. Residents were observed eating with some conversing. There was music playing in the background. Continued observation revealed the chairs the residents were seated in were tattered and partially torn.</p> <p>An interview with the Housekeeping and Laundry Supervisor in the nurses' station in the center of the facility 6/19/24 at 1:30 p.m. revealed he/she had a plan to deep clean one (1) hall each week. He/She stated the deep cleaning would include removing all resident belongings from the rooms and cleaning the walls, floors, baseboards, windows and bathrooms. He/She stated that he/she was appointed this position in April of this year and was still working on some things.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>26002</p> <p>Based on observation, interview and record review the facility failed to have Registered Nurses (RNs) on each shift daily.</p> <p>Review of the Payroll Based Journal (PBJ) Staffing Report CASPER Report from CMS dated FY Quarter 1 2024 (October 1 - December 31, 2023) revealed a One Star Staffing Rating for excessively low weekend staffing.</p> <p>An interview with the Staffing Coordinator and the Human Resources Manager for the facility on 6/19/24 at 1:00 p.m. in the conference room revealed there was no RN coverage on the night shift (11 p.m. until 7 a.m.) documented on the daily staffing forms provided for Saturday, 6/15/24, Sunday, 6/16/24, and upcoming shifts for evening or night shifts for 6/20/24. The Staffing Coordinator stated the Licensed Practical Nurses (LPNs) take charge and notify the Physicians, call families and emergency personnel in the event of emergencies.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>17500</p> <p>Based on observation and interview, the facility failed to ensure one (1) of six (6) medication carts was locked and all drugs and biologicals were in secured and locked compartments, on one (1) of six (6) floors outside of the nurse's station. This action did not ensure that these drugs and biologicals were not accessible to cognitively impaired residents.</p> <p>The findings include:</p> <p>Review of facility policy titled, Medication Storage Policy, dated 5/18/24 noted the following:</p> <p>Policy: I. General Guidelines:</p> <ol style="list-style-type: none"> 1. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. 2. Only authorized personnel will have access to the keys to locked compartments. 3. During medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/cart. <p>During facility tour and observation outside the nurse's station facing the 4th floor on 6/18/24 at 11:33 a.m., the medication cart was observed to be left unlocked and unattended. Certified Medication Technician (CMT) A did not have a visual view of the unlocked medication cart. There were noted to be visitors and residents who passed this vicinity of his/her medication cart.</p> <p>In an interview on 6/18/24 at 11:57 a.m. with Licensed Practical Nurse (LPN) A, he/she stated that the CMT should not have left his/her medication cart unlocked because there were cognitively impaired residents who may try to access the medication carts.</p> <p>In an interview on 6/18/24 at 1:35 p.m. with CMT A, he/she was asked if he/she was aware that he/she had left the medication cart unlocked and unsecured, and he/she stated, Yes, I was informed that I had left the medication cart unlocked.</p> <p>An observation on 6/20/24 at 1:15 p.m. revealed Resident #60, walking around the entire nursing station pulling on the medication carts' drawers, attempting to open a drawer to each cart. All carts were locked, and none were opened by Resident #60.</p> <p>In an interview on 6/20/24 at 1:30 p.m. with LPN B, he/she stated that Resident #60 walked around the entire nursing station throughout the day, pulling on the medication carts' drawers, attempting to open the drawers to each cart.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>12273</p> <p>Based on observation, interview, and record review the facility failed to ensure the preplanned menus and Diet Spreadsheets (which identified which foods and portion serving sizes should be served to each diet). Failure to ensure the preplanned menu was followed could place residents at risk for weight loss.</p> <p>The findings include:</p> <p>On 6/18/2024 between 11:30 am and 1:00 pm, during observation of the meal service in the main dining room, the meal served included creamed corn, baked beans, and pulled pork served on a hamburger bun.</p> <p>Review of the Week at a Glance - Week 1 menu revealed corn casserole and cornbread were included with the meal, however, these items were not observed being served.</p> <p>On 6/19/24 at 8:27 a.m., during observation of breakfast trayline, Dietary Aide (DA) D was observed plating foods to be served to residents seated in the main dining room. The entree item for the meal included sausage gravy served over biscuits. A white handled ladle was used to serve sausage and gravy over a biscuit, the DA D added one (1) ladle full of the entree to the plates being served.</p> <p>The Diet Spreadsheet, which identified what food and what portion serving size for each item served with the meal indicated a four ounce (4 oz) serving of the sausage gravy was the intended portion size.</p> <p>On 6/20/24 at 1:35 the DM, assisted with verifying the white ladle used to serve the entree held 1.6 ounces which was not the serving size identified on the spreadsheet.</p> <p>A review of the Week at a Glance - Week 1 menu showed the noon meal included chicken parmesan, buttered penne pasta and buttered peas, were identified as food items for the meal.</p> <p>On 6/20/24 the noon meal observation was completed between 12:15 p.m. and 1:30 p.m. Dietary Aides D and B prepared plates to be served to residents during the noon meal service. The pureed vegetable had a yellow handled ladle in the pan, and a white handled ladle had been placed in the meat entree. The puree diets were served a scoop of mashed potatoes, which were not identified on the menu and/or the Diet Spreadsheet.</p> <p>The Diet Spreadsheet indicated on 6/20/24, the pureed entree should have been served using a #6 scoop which held 5.5-ounces of the entree, and the vegetable should have been served using a #12 scoop which held 2 2/3-ounce portion. It also indicated pureed pasta should be served to the pureed diets, rather than the mashed potatoes serving they received.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/20/24 at 1:35 p.m. the Dietary Manager (DM) and Regional Food Service Supervisor (RFSS) were asked to verify the portion serving sizes of the yellow and white colored ladles used to portion foods for the puree diets. The handle of the yellow ladle was marked showing it held a 2 oz. portion instead of 2 2/3 ounce the menu identified, and the white handled ladle (also observed to serve the breakfast entree on 6/19/24) was labeled 1.6 oz instead of the 5.5 oz serving the menu identified.</p> <p>During the above interview, the DM was asked about the mashed potatoes served on tray line. He/She stated they were used in place of pureed pasta and commented pasta did not puree well. The DM was asked about the green beans served and explained the vendor had substituted the peas with green beans, because peas were not available. When asked about the corn casserole that was intended to be served on 6/18/24 for the noon meal, the RFSS stated the casserole was not prepared and therefore, the residents were served creamed corn. The DM also stated the pulled pork was served with a hamburger bun rather than the cornbread the menu that the diet spreadsheet identified.</p> <p>The Diet Spreadsheet indicated on 6/20/24, the pureed entree should have been served using a #6 scoop which held 5.5-ounces of the entree, and the vegetable should have been served using a #12 scoop which held 2 2/3-ounce portion. It also indicated pureed pasta should be served to the pureed diets, rather than the mashed potatoes serving they received.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>12273</p> <p>Based on observation, interview and record review the facility failed to ensure foods were stored, prepared and distributed under sanitary conditions as evidenced by: 1.) Failure to ensure food preparation areas and distribution equipment were stored under clean and sanitary conditions, 2.) Failure to ensure foods temperature logs were maintained to ensure the appropriate cooking temperatures were reached, and 3.) Monitor temperature and sanitizer concentration for the dish machine. Failure to meet these requirements could place residents at risk for food borne illness.</p> <p>The findings include:</p> <p>1. Failure to ensure food was stored, prepared, and distributed under sanitary conditions.</p> <p>On 6/18/24 between 10:20 a.m. and 10:40 a.m., during a joint tour of the kitchen with the Dietary Manager (DM), the following observations were noted:</p> <p>Two (2) plastic bins which contained serving utensils (approximately 10-15) were observed under a food preparation counter. The bin lids were open and black colored crumbs and food crumbs were observed scattered in and around the utensils.</p> <p>Bins with lids that contained dry goods were stored under another food preparation counter. The clear plastic lids were soiled with crumbs and dried food spills. The bin also had visible crumbs and food matter scattered on the inside.</p> <p>Clear plastic bins that held bowls and cups were observed had spills, dried water spots and food splash visible on and inside the bins.</p> <p>A tray of glasses stacked directly on the tray, had water droplets and condensation visible inside the glasses.</p> <p>The Robot Coupe (a commercial food processor) was observed on the base with the lid attached. The food processor bowl had standing water in the bottom, and condensation had accumulated in the interior.</p> <p>At 10:25 a.m. the DM agreed the storage areas for utensils described above were not sanitary, and also acknowledged dishware and equipment should be air dried after washing.</p> <p>The grease tray under the grill was full, the DM commented it was used the previous day, and commented it had not been cleaned after use.</p> <p>At 10:30 a.m., a convection steam oven was observed with a two (2) inch deep steamtable pan under the cooking unit. It contained a milky white fluid approximately one and a half (1 1/2) inches deep in the pan. The DM opened the door on the unit and the door seal (a rubber gasket intended to seal the door) was cracked and/or broken.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The walk-in refrigerator had a box of Health Shakes, which were delivered frozen and were thawing. The box had two (2) different dates written on the outside of it; one (1) was 6/6 and the other was 6/9. When asked what dates meant, the DM stated they were not sure. (The product has a shelf life of 14 days after thawing.) However, because two (2) dates were documented, there was no way of knowing when the shakes had been thawed and/or when they needed to be discarded.</p> <p>Also in the walk-in refrigerator, a deep steam table pan full of baked potatoes was dated 6/11. The DM commented that the facility only kept food for three (3) days after cooking and if not used, it was discarded.</p> <p>In the dry storage room an open, undated 32 ounce (oz.) carton of apple juice was on the shelf. At 10:32 a.m. , the DM stated items should be dated when opened, then said the juice needed to be dated when opened and refrigerated and he/she then discarded the carton.</p> <p>2. Not ensuring cooking temperatures of raw meats and other foods were consistently monitored to ensure the final proper cooking temperature was attained and ensure the temperature and concentration level of sanitizer of the dish machine were consistently monitored.</p> <p>Upon entering the kitchen on 6/19/24 at 2:40 p.m., Dietary Aide (DA) A was preparing a cooked roast beef. One (1) sheet pan contained roast beef slices and the pan next to it had chunks of roast beef on it. When asked if the temperatures had been taken DA A said yes. When asked to see a log of the temperatures, DA A said they checked them but did not document the temperatures. DA A was asked to check the temperatures of the pieces of roast beef and the two (2) smaller pieces reached a temperature of 145 Degrees Fahrenheit (F), but when the temperature of the large piece of the roast was tested an internal temperature of 138 F was obtained. DA A stated the large piece would be placed back in the oven to cook to an internal temperature of 145 F.</p> <p>On 6/19/24 at 2:45 p.m., the DM was asked about the food temperature logs. The DM then obtained a binder and explained the food temperatures were documented prior to service. When asked if a log was kept to document the final cooking temperatures, the DM stated no. He/She then stated they documented the temperatures when foods are set up on the tray line.</p> <p>3. Failure to ensure the temperature and concentration of sanitizer of the dish machine were monitored routinely.</p> <p>On 6/18/24 at 10:20 a.m., during the initial tour in the kitchen when asked about the dish machine, the DM explained it was a low temperature dish machine and used a rinse additive to sanitize the dishware. The exterior of the dish machine had no visible temperature gauge. When asked if they monitored the temperature, the DM stated they did not. When asked if they could test the sanitizer to ensure it was the right concentration, the DM obtained a test strip and tested the rinse cycle. The reading showed the concentration of the sanitizer was at the correct strength. When asked how often the sanitizer or temperature were tested , the DM stated, when needed and commented if the staff thought the machine was not working correctly. When asked if a log of the results of any testing was documented, he/she responded no.</p>		

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NAME OF PROVIDER OR SUPPLIER Crestwood Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11400 Mehl Avenue Florissant, MO 63033	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>34870</p> <p>Based on observation, interview and record review, facility staff failed to sanitize their hands before they entered the room, during medication administration, and after they exited the room to prevent the spread of infection. This action affected two (2) residents (Resident #89 and Resident #83). Additionally, facility staff failed to remove their gloves and sanitize or wash their hands after they placed plastic liners into trash cans to be delivered to resident rooms.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Medication Administration, undated, documented the following:</p> <p>Policy:</p> <p>Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.</p> <p>Policy Explanation and Guidelines:</p> <p>4. Wash hands prior to administering medication per facility protocol and product.</p> <p>On 6/19/24 at 8:24 a.m., Medication Administration was observed on Hall 200. Certified Medication Technician (CMT) HH administered seven (7) medications to R #89. CMT HH failed to hand sanitize before entering the room, during medication administration, and after exiting the room.</p> <p>CMT HH also administered 10 medications to R #83 and failed to hand sanitize before entering the room, during medication administration, and after exiting the room.</p> <p>In an interview on 6/19/24 at 8:45 a.m., CMT HH stated he/she should have used hand sanitizer throughout the medication administration process.</p> <p>In an interview on 6/19/24 at 9:07 a.m., the Director of Nursing (DON) stated hand sanitation must be used by all staff during medication administration.</p> <p>On 6/21/24 at 10:45 a.m., Registered Nurse (RN) II confirmed hand sanitation should be performed when administering medication and providing care.</p> <p>2. On 6/20/24 at 11:50 a.m., two (2) housekeeping staff were observed in the 200 hall; both were wearing gloves. They were observed placing plastic liners in a stack of trash cans, which were being delivered to resident rooms. When asked about handwashing, Housekeeper (HK) E displayed that he/she was wearing two (2) pairs of gloves. HK E explained after they finished cleaning a room the top pair of gloves was discarded, and a clean pair was placed over the second pair of gloves. When asked when hand hygiene was performed HK E said the sink to wash their hands was in the housekeeping closet. When asked if the cart had any hand sanitizer on it, HK E said no.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/20/24 at 12:15 p.m. the Housekeeping Supervisor (HS) was interviewed. The HS stated the expectation was to remove gloves after cleaning each room and complete hand hygiene before they applied new gloves and moved to the next resident room for cleaning.</p> <p>3. Review of the policy titled, Dietary - Equipment Operations, Infection Control and Sanitation Policy, dated 2/2/24 included under F. Dish Machine 5. Dishwashing Procedure the following:</p> <p>Either two [2] people are in the dish room, one [1] on dirty side, one [1] on the clean side or if one [1] person does both they must wash and sanitize hands between dirty and clean areas. [sic]</p> <p>On 06/18/24 from 10:20 a.m. to 11:49 a.m., during a tour of the kitchen with the Dietary Manager (DM), Dietary Aide (DA) A was rinsing soiled dishes and loading them into racks to wash in the dish machine. DA A then discarded a set of gloves, placed new gloves on without completing hand hygiene and began to stack clean plates. When asked if they had washed their hands, DA A stated, I am wearing gloves. The DM stated the staff were expected to discard soiled gloves and wash their hands prior to starting a clean task (e.g., stacking clean dishes). The DM then coached DA A to change gloves and complete hand hygiene between handling soiled and clean items.</p> <p>On 6/19/24 at 10:34 a.m., DA C was observed working in the dishwashing area. DA C wore gloves, worked on the soiled side of the dish machine and moved to the clean side of the dish machine to stack clean dishes. He/She did not remove their soiled gloves and/or complete hand hygiene. DA C was asked about handwashing and admitted they had not changed gloves or washed their hands prior to stacking clean dishes on the clean side of the dish machine.</p> <p>On 6/20/24 at 1:10 p.m., DA B left the tray assembly line and exited the kitchen. At 1:14 p.m., DA B returned to the service area, put on latex gloves, and began preparing plates of food for service on the trayline. He/She did not complete hand hygiene prior to resuming tray line service.</p>		