STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265824	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 42594 Based on interview and record review, the facility failed to issue an appropriate discharge notice to one resident (Resident #4) of nine sampled residents. The facility failed to document an appropriate location to which the resident would be discharged , failed to ensure the physician documented in the resident's medical record the specific needs the facility could not meet, and failed to provide the explanation of the right to appeal to the state (the name, address and phone number of the state entity which receives appeal hearing requests). The facility census was 117. Review of the facility policy Discharge Summary and Plan, dated 12/2022, showed the following: -Every resident is evaluated for his/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/her family and includes: where the individual plans to reside, arrangements that have been made for follow up care and services, a description of the resident's stated discharge goals, what factors may make the resident vulnerable to preventable readmission and how those factors will be addressed; -The resident/representative is involved in the post discharge planning process and informed of the final post discharge plan; A copy of the following is provided to the resident and receiving facility, and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs, the post discharge plan and the discharge summary. 1. Review of Resident #4's annual Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff, dated 4/12/24, showed the following: -The resident's cognition was severely impaired; -The resident rejected care; -The resident had physical and verbal behaviors; (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was inattentive and had disorganized thoughts; -The resident's behaviors put the resident at risk for physical illness and/or injury, interfered with the resident's care, activities, and social interactions; -The resident's behaviors put other residents at risk for physical injury and a significant disruption in care or their living environment; -The resident had diagnoses that included dementia (a progressive disease that destroys memory and other important mental functions), arthritis, post-polio syndrome (muscle and joint weakness and pain that gets worse over time), and other neurological conditions. Review of the resident's Notice of Proposed Transfer/Discharge, dated 8/14/24, showed the following: -Date of discharge was 9/14/24; -Disposition/location of discharge: hospital/home; -Transfer/discharge reason: the safety of the individuals in the facility would be endangered by the resident being at the facility; -The notice was signed by the administrator; -The notice did not have a proper discharge location; -The facility did not provide the Department of Health and Senior Services Appeals Unit information on the notice. Review of the resident's face sheet, dated 8/20/24, showed the resident's family member was the durable power of attorney (DPOA) for his/her healthcare and finances. Review of the resident's medical record showed no documentation by the resident's physician regarding what needs the facility could not meet and what the facility had attempted to meet those needs. During an interview on 8/19/24 at 1:11 P.M., the resident's Durable Power of Attorney (DPOA) said the following: -On 8/3/24, the facility decided to send the resident to the emergency department at a psychiatric hospital so he/she could be admitted to the hospital for an evaluation. The family agreed but did not know it would take 11 days to be admitted to the hospital from the emergency department; -On 8/14/24, the administrator called the DPOA and told him/her that the resident was going to be discharged because they felt he/she was a threat to other residents. He said he would email the discharge notice; -The DPOA got the discharge notice on 8/15/24 by email; (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Social Worker E sent a referral to a psychiatric facility but they did not accept the resident; -Social Worker E told the DPOA it was the DPOA's responsibility to find facilities he/she wanted referrals sent to and Social Worker E would send all the paperwork; -The facility was not much help finding a facility for the resident to go to. During an interview on 8/28/24 at 8:58 A.M., the administrator said the following: -He thought he had the correct appeals information needed on a discharge notice; -He did not think he had to have physician documentation in the resident's medical record regarding the needs the facility could not meet for the resident because it was not an emergency discharge notice; -This was the first time he had issued a discharge notice. MO240598

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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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594 Based on observation, record review and interview, the facility failed to ensure one resident (Resident #3) received an antibiotic and a probiotic to treat a urinary tract infection (UTI) as ordered by the physician. The assistant director of nursing (ADON) received a verbal order from the resident's physician on 8/2/24 for Florastor (probiotic) that was never entered on the resident's medication administration record to administer and on 8/7/24 she received another verbal order to discontinue Macrobid (antibiotic) and start Cipro (antibiotic). She discontinued one antibiotic but did not enter the order in the resident's electronic medication administration record for the new antibiotic. This resulted in the resident being hospitalized for his/her continued untreated symptoms from the UTI. The facility census was 117. Review of the facility policy Verbal Order, dated 2021, showed the following: -Verbal orders shall only be given in an emergency or when the attending physician is not immediately available to write or sign the order; -Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his/her behalf; -The individual receiving the verbal order must write it on the physician's order sheet as a verbal order. 1. Review of Resident #3's care plan, dated 3/1/24, showed the following: -The resident was at risk for activities of daily living and mobility decline and required assistance related to anticipated declines in condition due to disease process; -Assist with toileting as needed. The resident was incontinent of bowel and bladder. Encourage and assist the resident with toileting frequently and provide peri care; -The resident had diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), type two diabetes with diabetic nephropathy (deterioration of kidney function), hemiparesis (weakness of one entire side of the body) and hemiplegia (the loss of voluntary movement of one side of the body), and aphasia (difficulty speaking) following a stroke. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 5/16/24, showed the following: -The resident's cognition was severely impaired; -The resident did not have any behaviors and did not reject care; -The resident required substantial/maximum assist from staff for toileting; (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	-The resident was occasionally incontinent of bladder; -The resident was always continent of bowel; -The resident was dependent on staff for transfers from sitting to standing and from chair to bed. Review of the resident's progress note, dated 7/17/24, showed the following: -Straight catheter (a tube inserted into the bladder to drain urine and then taken out right after it is used) for a urine analysis (UA); -Moderate amount of foul, dark, cloudy, amber urine. Review of the resident's progress note, dated 7/29/24 at 1:17 P.M., showed the following: -A new order to collect urine for a UA with a culture and sensitivity (test to determine which bacteria are in the urine and which antibiotic would best treat the infection) test tonight; -Urine will be picked up tomorrow morning. Review of the resident's progress note, dated 8/2/24, showed the following: -The ADON received a partial UA result and reported to resident's physician; -The physician gave a new order to start Macrobid (antibiotic) 100 milligrams (mg) two times a day for seven days; -The physician gave a new order to start Florastor (probiotic) 250 mg two times a day for 14 days. Review of the resident's final lab results report, dated 8/2/24, showed the following: -The urine was collected on 7/29/24; -The lab received the urine on 7/30/24; -The lab reported the culture and sensitivity to the facility on [DATE] at 12:23 P.M.; -The report contained abnormal results; -The results showed the culture and sensitivity test found Enterobacter aerogenes (bacteria generally found in the gastrointestinal tract) in the resident's urine that required a specific antibiotic, Cipro, that the bacteria would be most sensitive to; -The Director of Nursing (DON) reviewed the resident's results on 8/4/24 at 10:44 A.M. (two days after the results were sent to the facility). Review of the resident's progress note, dated 8/7/24, showed the following: (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	-A culture and sensitivity report was received for the resident's UA; -The ADON reported the results to the resident's physician; -The physician gave a new order to discontinue Macrobid; -The physician gave a new order to start Cipro (antibiotic) 250 mg two times a day for seven days. Review of the resident's undated physician order sheet showed no documentation staff transcribed the orders for Florastor or Cipro to the resident's Medication Administration Record (MAR), as ordered by the physician. Review of the resident's MAR, dated August 2024, showed the following: -Macrobid was started on 8/3/24 and discontinued on 8/7/24; -Florastor was not on the resident's August MAR; -Cipro was not on the resident's August MAR. Review of the resident's hospital discharge records, dated 8/16/24, showed the following: -The resident was admitted with vomiting, an abnormal UA and possible pneumonia; -The resident was diagnosed with pyelonephritis (severe kidney infection). During an interview on 8/21/24 at 10 :49 A.M., the ADON said the following: -She gave a note to a nurse (unknown name) to enter the order for Cipro into the resident's electronic medical record; -The order just got missed and the resident did not get the newly ordered antibiotic; -She would think since the resident did not get the antibiotic it had a negative effect on the resident and caused the resident to go to the hospital; -Lab results should be reported to the physician the day they are reported to the facility. During an interview on 8/21/24 at 1:15 P.M., the Director of Nursing (DON) said the following: -She expected physicians to be notified of abnormal lab results immediately; -She expected the ADON to enter the antibiotic order and not pass it off to another nurse to enter. **need more interview as to why she did not report to the physician when she reviewed report on 8/4/24** During an interview on 8/26/24 at 4:18 P.M., the resident's physician said the following: (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	-He learned from the resident's family member that the staff did not administer the Cipro to the resident as ordered; -Staff should have administered the Cipro. He did culture and sensitivity tests to make sure his residents received the correct antibiotic to best fight an infection; -He was not aware the resident did not receive Florastor as ordered; -Pyelonephritis is the most serious infection. When an infection got to this point it meant the infection has gone from the bladder to the ureters (tubes that carry urine to the bladder) and up to the kidneys; -The resident definitely may have avoided a trip to the hospital and an infection as serious as pyelonephritis if he/she had received Cipro as he had ordered. MO240413

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 42594 Based on observation, interview, and record review, the facility failed to ensure the planned menu, reviewed by the Registered Dietician, was followed and items listed on the menu served to the residents. The facility also failed to serve the correct serving sizes per the menu. The facility's census was 117. Review of the facility policy Food and Nutrition Services, dated 10/2017, showed the following: -Each resident is provided a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident; -Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. 1. Review of the spread sheet signed by the Registered Dietician (RD), dated 4/17/24, showed the lunch meal was to include cheeseburger with French fries, relish plate, and ambrosia deluxe. The meal was to be served on 8/20/24. Review of the menu dated 8/20/24 showed the noon meal included: -Chicken Rice Soup; -Turkey burger; -Potato Wedges; -Apple cider slaw; -Double chocolate brownie. Observation on 8/20/24 from 12:15 P.M. to 12:45 P.M. showed: -Staff did not serve chicken and rice soup or a substitute; -Staff served a turkey burger with lettuce, tomato and pickles on a bun, potato wedges, apple cider slaw and a double chocolate brownie; -Multiple residents did not eat the turkey burger. They sent it back because they thought it was not cooked all the way through due to the appearance of the burger being very light in color. During an interview on 8/20/24 at 12:42 P.M. Dietary Aide A said: -He/She served what was on the menu and what was prepared by the cook in the kitchen; (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The chicken and rice soup was not prepared and no substitution was available. 2. Review of the spread sheet signed by the RD, dated 5/11/24, showed the meal was to include corned beef, hot potato salad, seasoned cabbage, wheat roll and cherry cobbler. The meal was to be served on 8/20/24. Review of the menu dated 8/20/24 for the dinner meal showed: -Garden Salad; -Corned beef and cabbage; -Parsleyed potatoes; -Roasted Brussels sprouts; -Banana pudding. Observation on 8/20/24 at 4:50 P.M. showed: -Dietary staff served corned beef and cabbage, diced potatoes with the skin on and banana pudding; -Staff did not serve the dinner salad or roasted Brussels sprouts or equivalent substitutions. 3. Review of the spread sheet signed by the RD for a dinner meal, dated 5/6/24, showed the meal was to include deli sandwich on wheat bread (crossed out and BLT was hand written in it's place), relish plate, mayonnaise packet and chilled fruit cup. The meal was to be served on 8/21/24. Review of the menu dated 8/21/24 for the noon meal showed: -Hearty vegetable soup; -BLT (bacon, lettuce and tomato) sandwich on wheatberry bread; -Homemade potato chips; -Fresh fruit and Jello. Observation on 8/21/24 at 12:25 P.M. of residents eating lunch in the main dining room, showed small uncovered bowls of green Jello on a table at the front of the dining room. Each bowl of Jello had different amounts in them (half full, one fourth full, and one third full) that staff served to the residents. The Jello was melted in the bowls with liquid in the bottom of the bowls. During an interview on 8/21/24 at 12:35 P.M. Dietary Aide D said the following: -He/She just used his/her instincts to dish up the Jello for the residents; -He/She did not use certain scoop sizes to dish up food to be served to the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 12:26 P.M. Resident #9 said the following: -He/She asked for another BLT sandwich because he/she only got a half of a sandwich; -A lot of times the kitchen ran out of food and didn't serve what was on the menu; -One day they were supposed to have Philly cheese steak sandwiches and then it ended up being something totally different; -Last night they were supposed to have Brussel sprouts and they did not get them. The resident was very disappointed because he/she really liked Brussel sprouts. The resident did not have a garden salad last night because the dietary aide forgot to serve it at the beginning of the meal and tried to serve it to the resident after he/she had eaten dessert. Observation on 8/21/24 at 12:00 P.M. to 12:30 P.M. showed dietary staff served the following: -BLT sandwich on bread with mayonnaise spread on the bread, there were different amounts of bacon on each sandwich, a piece of lettuce, and a slice of tomato; -Store bought potato chips and a fresh fruit cup; -Staff offered soup to the residents but did not serve each resident a bowl of soup or provide an alternative. During an interview on 8/21/24 at 12:30 P.M. and 5:45 P.M., the Dietary Manager said: -The cook did not prepare the chicken and rice soup for 8/20/24 and did not communicate to staff that the soup was not made; -She did not arrive to work on 8/20/24 until 11:00 A.M. and then it was too late to make the chicken and rice soup for lunch; -She was not aware staff did not serve the garden salad to residents until after dessert. -On the day Philly cheese steak sandwiches were on the menu, she asked the cook why it was not prepared and served. The cook told her he/she could not find the steak for the sandwiches so he/she just made something else. -Brussel sprouts on the menu for supper on 8/20/24 should not have been on the menu. It was a typo and should have been deleted. She didn't think they needed cabbage and Brussels sprouts; -She served three to four slices of bacon on each full sandwich, enough bacon so the residents wouldn't complain and whatever looked good; -The residents did not like the homemade potato chips so she served regular potato chips. -She prepared the menus by looking at the spreadsheets the Registered Dietician signed and approved and adjusted them to make the menus for the residents the best she could. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 2:30 P.M. the Registered Dietician said: -She reviewed and signed off on the spreadsheet earlier in the year; -There should be a menu that correlated to the spreadsheet; -The spreadsheet should be used for the different textures of food and specialized diets of what foods could and could not be served along with the required vitamins, such as Vitamin A; -She did not recognize the menu that was provided by the Dietary Manager to the surveyor and questioned where the menu came from; -If Brussel sprouts were not served for the meal on 8/20/24, the residents did not receive all of the vitamin A foods that were recommended; -No one told her the facility had not been preparing meals according to the spreadsheets. During an interview on 8/21/24 at 6:00 P.M. the Administrator said: -The Dietary Manager made out the menu; -He would assume that the spreadsheet menus met the requirements since it was signed off by the Registered Dietician and therefore should be followed by the Dietary Manager in meal preparation including portion sizes. MO240413

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42594 Based on observation and interview, the facility failed to comply with state laws and designate a person as an administrator currently licensed in the state as a nursing home administrator. This had the potential to affect all facility residents. The facility census was 117. Review of the facility policy, Administrator, dated ,d+[DATE], showed the following: -A licensed administrator is responsible for the day to day functions of the facility; -The governing board of this facility has appointed an administrator who is duly licensed in accordance with current federal and state requirements; -Should an administrator license expire, the facility has 10 days to have a fully licensed administrator step into the position; -In the absence of the administrator, the assistant administrator or director of nursing services was authorized to act in the administrator's behalf. Observation on [DATE] at 10:13 A.M., of the hallway leading to the entrance of the administrator's office showed the following: -A State of Missouri Temporary Emergency License displayed on a table outside the administrator's office; -The temporary license was issued on [DATE] and expired on [DATE]. During an interview on [DATE] at 11:00 A.M. and [DATE] at 5:58 P.M., the administrator said the following: -His temporary license expired on [DATE]; -He has acted as the operations manager since [DATE]. The duties were the same as the administrator's (to oversee the day to day operations of the facility), he just couldn't sign any documents as the administrator; -He spoke with the interim administrator at the end of last week ([DATE] - [DATE]); -The interim administrator was to start today ([DATE]); -He issued and signed a discharge notice to a resident on [DATE], acting as the administrator; -He felt the discharge notice was valid except for his signature. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He thought the facility had 10 days to have a licensed administrator in the building after his temporary license expired. Observation on [DATE] at 3:00 P.M. showed the interim administrator entered the facility for the first time. Observation on [DATE] from 7:45 A.M. to 7:30 P.M. showed the interim administrator was not in the facility. During an interview on [DATE] at 3:19 P.M., the interim administrator said the following: -She first spoke with the facility administrator on [DATE]; -She would be the interim administrator for the skilled nursing portion of the facility. During an interview on [DATE] at 4:44 P.M., the Regional [NAME] President of Operations said the following: -The administrator told him his temporary emergency license expired on [DATE]; -The administrator did not meet all the guidelines to have his administrator's license application reviewed by the Missouri Board of Nursing Home Administrators in [DATE]; -The administrator should have been on top of getting a licensed administrator in the facility to start on [DATE]. MO240622

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42594 Based on interview and record review, the facility failed to designate one or more individuals, who was qualified by completing specialized training in infection prevention and control, as the Infection Preventionist (IP) responsible for the facility's Infection Prevention and Control Program. The facility census was 117. Review of the facility policy, Infection Prevention and Control Program, dated 12/2023, showed the following: -An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections; -The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under contractual arrangement; -The IPCP is coordinated and overseen by an infection prevention specialist (Infection Preventionist); -Data gathered during surveillance is used to oversee infections and spot trends. During an interview on 8/21/24 at 1:15 P.M., the Director of Nursing (DON) said the following: -The facility had not had an Infection Preventionist (IP) for a while; -She just got her IP certification this past weekend; -There has been no tracking of infections or antibiotics; -She had seen a trend in urinary tract infections but didn't know which residents had them or what was being done for them. During an interview on 8/21/24 at 5:58 P.M., the Administrator said the following: -The facility did not have an IP until the DON recently got certified; -He would have expected someone to be tracking infections in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265824	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 42594 Based on observation, interview, and record review, the facility failed to maintain the water faucet in the food preparation area in the kitchen. The faucet would not turn off and water ran continuously at approximately half flow. The facility census was 117. Review of the facility policy Maintenance Service, dated 12/2009, showed the following: -The maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times; -Functions of maintenance personnel included but were not limited to maintaining the plumbing fixtures. Review of the facility Maintenance Request Log, dated 7/1/24, showed the following: -The Dietary Manager put in a work request for a sink in the prep area that was leaking; -The Maintenance Director marked the status of the leaking sink as done. Review of the facility Maintenance Request Log, dated 8/13/24, showed the following: -The Dietary Manager put in a work request for a sink in the prep area that did not have hot water; -The Maintenance Director marked the status of the leaking sink as done. Observation on 8/20/24 at 11:54 A.M. showed the faucet in the food preparation area was running at approximately half flow and would not turn off. During an interview on 8/21/24 at 9:01 A.M., the Maintenance Director said he did not get a work order for a running faucet in the kitchen. During an interview on 8/21/24 at 9:47 A.M., the Dietary Manager said the following: -On 7/1/24 she put in a work order for the sink in the food preparation area because it was leaking, it was a stream of water and it would not shut off; -Maintenance said they fixed the leak but then there was not hot water in the sink; -On 8/13/24 she put in a work order for the sink in the food preparation area because there was no hot water; -There was hot water now, but the faucet never shut off and continues to run 24/7. Observation on 8/21/24 at 9:47 A.M. showed the faucet in the food preparation area was running at approximately half flow and would not turn off. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265824	A. Building B. Wing	08/21/2024

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/24 at 6:56 P.M., the Administrator said the following: -He did not know about the facet in the kitchen that ran continuously at about half flow; -He expected the Dietary Manager to put in a work order and the maintenance department to fix the faucet.