STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure three residents (Resident #2, #5 and #44), in a review of three sampled residents who received insulin injections, were free from significant medication errors. Staff failed to prime (remove the air) the Humalog/Novolog Kwik pen (prefilled pen of fast acting insulin) (medication injected under the skin used to treat diabetes) needle as instructed by the manufacturer prior to administration of the medication, resulting in administration of less than the ordered dose of Humalog/Novolog. Staff failed to hold the needle against the resident's skin for the manufacturer's suggested time after the administration of the medication. The facility census was 48. Review of the undated facility policy, Medication Administration, showed the following: -The facility will provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing and administering of all medications to meet the needs of each resident; -If the charge nurse/Certified Medication Technician (CMT) is unfamiliar with the medications, he/she should look it up in the nurse's drug handbook, call the pharmacist and/or physician for clarification, and/or look for the manufacturer guidelines if it is a recently released medication.	F 760		

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

Administrator 4/22/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 1 Review of the Humalog Kwik pen/Novolog Flex pen package insert showed the following in part: -Humalog Kwik Pen was a disposable single-patient-use prefilled pen containing 300 units of Humalog insulin. Each turn (click) of the dose knob dialed one unit of insulin. You could give from one to 60 units in a single injection; -Novolog Flex pen was a disposable single-patient use prefilled pen containing 300 units of Novolog insulin. Each turn (click) of the dose knob dialed one unit of insulin. You could give from one to 60 units in a single injection; -Pull the pen cap off, wipe the rubber seal with alcohol swab, check the liquid in the pen and ensure the liquid was clear. Select a new needle, remove the paper tab from the outer needle shield, push the capped needle straight onto the pen and twist the needle on until tight. Pull off the outer needle shield and remove the inner needle shield; -Prime (remove the air from the needle and cartridge). If you do not prime before each injection you may get too much or too little insulin. Turn the dose knob to select two units, hold the pen with the needle pointed up, tap the cartridge holder gently to collect air bubbles at the top, push the dose knob in until it stops and "0" is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Repeat the priming procedure if you did not see insulin at the tip of the needle; -Turn the dose knob and select the number of units you need to inject and administer the medication; -Choose your injection site. Humalog/Novolog is injected subcutaneously (under the skin) in your stomach area, buttocks, upper legs, upper arms; -Wipe skin with an alcohol swab and let the skin	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 2	F 760		

dry before you inject your dose;
-Insert the needle into the skin. Push the dose knob all the way in;
-Continue to hold the dose knob in and slowly count to five before removing the needle.

1. Review of Resident #5's April 2024 Physician Order Sheets (POS) showed the following:
-Diagnosis of type 2 diabetes mellitus with hyperglycemia (high amount of sugar in the blood);
-Humalog Kwik Pen Insulin 100 units/milliliter (ml) subcutaneous (tissue just below the skin) inject 15 units three times a day.

Observation on 4/2/24 at 8:08 A.M.. showed the following;
-CMT B obtained the resident's Humalog Kwik pen from the top medication cart drawer, removed the lid, cleaned the tip with an alcohol pad and attached a new sterile needle;
-CMT B did not prime the insulin pen;
-CMT B dialed up 15 units of Humalog insulin and administered the medication in the resident's subcutaneous tissue of the abdomen;
-CMT B did not hold the dose knob in for five seconds before removing the needle.

Observation on 04/02/24 at 12:27 P.M. showed the following:
-CMT I obtained the resident's Humalog Kwik pen from the medication cart, cleaned the tip with an alcohol pad and attached a new sterile needle;
-CMT I did not prime the the insulin pen;
-CMT I prepared the resident's Humalog insulin, cleansed the site and administered the medication in the subcutaneous tissue of the right abdomen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 3 2. Review of Resident #44's April 2024 Physician Order Sheets (POS) showed the following: -Diagnosis of type 2 diabetes without complications; -Novolog flex pen Insulin 100 units/ml subcutaneous per sliding scale (a dose amount to be determined based on a finger stick procedure that determines the amount of sugar in the blood); for blood sugar of 100-151 administer two units, blood sugar 151-200 administer four units, blood sugar 201-250 administer six units, blood sugar 251-300 administer eight units, blood sugar 301-350 administer 10 units, blood sugar greater than 351 call physician for orders. Observation on 4/2/24 at 12:25 P.M. showed the following: -CMT B obtained the resident's blood sugar level with results of 155 milligrams per deciliter (mg/dL) (measurement of the amount of glucose or sugar in the blood) and determined Novolog sliding scale Insulin dose was to be four units; -CMT B obtained the resident's Novolog flex pen from the top medication cart drawer, removed the lid, cleansed the tip with an alcohol pad and attached a new sterile needle. CMT B did not prime the insulin pen; -CMT B dialed up four units of Novolog insulin and administered the medication in the resident's subcutaneous tissue of the abdomen; -CMT B did not hold the dose knob in for five seconds before removing the needle. 3. Review of Resident #2's quarterly Minimum Data Sheet (MDS), a federally mandated form completed by facility staff, dated 01/04/24, showed his/her diagnoses included Type 2 diabetes mellitus with diabetic polyneuropathy.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 4	F 760		

Review of the resident's April 2024 POS showed the following:
-Accu check (a rapid test of glucose concentration in the blood) before meals and at bedtime;
-Humalog Injection Solution, inject as per sliding scale: if blood sugar 150-200, administer two units; blood sugar 210-300, administer four units; blood sugar 301-350, administer six units; blood sugar 351-400, administer eight units; blood sugar 401-450, administer 10 units, subcutaneously before meals and at bedtime for hyperlgycemia.

Observation on 04/02/24 at 11:37 A.M. showed the following:
-CMT B obtained the resident's blood sugar level with results of 306 mg/dL and determined Humalog insulin sliding scale dose was to be six units;
-CMT B obtained the resident's Humalog Kwik pen from the medication cart, cleaned the tip with an alcohol pad and attached a new sterile needle;
-CMT B did not prime the insulin pen;
-CMT B dialed up six units of Humalog insulin, cleansed the site and administered the medication in the subcutaneous tissue of the left upper arm;
-CMT B did not hold the dose knob in for six seconds after administration.

4. During an interview on 04/02/24 at 12:28 P.M., CMT I said the following:
-He/She does not prime pre-filled insulin pens;
-He/She had been taught to place the new sterile needle, then dial up the dose, this pulls the air from the needle, which acted as priming.

During an interview on 04/03/24 at 8:36 A.M.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 5 CMT B said he/she primes the new sterile needle by placing the needle, then dialing up the insulin at least one unit past the ordered dose, then dialing back down to the ordered dose. During an interview on 04/04/24 at 10:07 A.M., Licensed Practical Nurse (LPN) J said the following: -When administering insulin by pre-filled pen route, two units should always be wasted after placing the needle. This is the act of priming the needle; -Without priming the needle, the full dose will not be administered. During an interview on 04/05/24 at 11:17 A.M., the Director of Nursing said the following: -She expected staff to prime insulin needles; -She expected staff to hold following administration; -She expected staff to administer insulin in accordance with facility policy, physician orders, and manufacturer guidelines.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 6 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to keep lorazepam (a schedule IV narcotic anxiety medication with the potential for abuse) behind two locks when it was stored in the unlocked refrigerator in the lower level medication room, without evidence of when the medication was dispensed or a narcotic sheet for reconciliation. The facility failed to remove and destroy discharged resident medications from the lower level medication room for eight discharged residents (Residents #100, #101, #102, #103, #104, #105, #106, and #107) as directed by facility policy. The facility census was 48. Review of the facility undated policy, Medications - Narcotics/Controlled Substances, showed the following: -Narcotics must always be stored under a double locking system; -They must be kept in the locked box in the unit's locked medication; -Each narcotic that the pharmacy dispenses to the facility is accompanied by a narcotic sheet with:	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 7 a. Medication name, amount, dose, and strength; b. Date dispersed to facility; c. Resident's name; d. Lines to record each dose removed, date and time, and signature; -Discontinued narcotics must be placed in the locked box in the medication room with their narcotics sheets attached; -Controlled substances that are no longer needed in the facility may be disposed of in the facility; -The Director of Nursing (DON)/Designee and one additional licensed person (licensed nurse or consultant pharmacist) will destroy discontinued narcotics together and sign the necessary documentation for that action. Review of the facility policy, Medication Storage in The Facility, dated February 2020, showed the following: -All drugs classified as Schedule II of the Controlled Substance Act will be stored under double locks; -Schedule III-V medications must be maintained in separately locked, permanently affixed compartments and cannot be stored with other nonscheduled medications. Review of the facility undated policy, Medication Destruction, showed the following: -The facility will dispose of unused and/or expired medications according to state, federal, local ordinances and current standards of practice; -Expired and/or discontinued medications should be removed from the medication cart and brought to the DON office; -The DON will place the medications in a locked cabinet awaiting disposal; -A record will be kept of the name of the resident,	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 8	F 761		

medication name, number of remaining pills, patches or liquid amount along with the narcotic count sheet, if applicable;
-The DON, along with a second licensed nurse, will dispose of all unused and/or expired medications every 30 days;
-The DON will maintain the records according to facility guidelines.

Review of the Bureau of Narcotics and Dangerous Drugs, Controlled Substance Guidelines for Missouri Practitioners, dated 8/28/23, showed if controlled substances are stored in a refrigerator, then the refrigerator must have a lock.

1. Review of Resident #100's physician orders, dated 5/19/21, showed an order for ketorolac tromethamne solution (eye drops used to treat itching, pain, burning, and inflammation of the eye) 30 milligrams (mg)/milliliter (ml).

Review of the facility clinical census showed the resident was discharged on 6/02/22.

Observation on 4/02/24 at 4:00 P.M., of the lower level medication storage room, in the middle drawer of the cabinet, showed 16 vials of ketorolac tromethamne solution 30 mg/ml labeled to be used for the resident.

The medication had not been pulled for destruction or destroyed per facility policy and remained in the facility 671 days after the resident was discharged.

2. Review of Resident #101's physician orders, dated 3/12/23, showed an order for NovoLog

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 9 insulin (injectable medication to lower blood sugar) solution 100 unit/ml. Review of the facility clinical census showed the resident was discharged on 3/13/23. Observation on 4/02/24 at 4:00 P.M., of the refrigerator in the lower level medication storage room, showed one unopened bottle of NovoLog injection solution 100 unit/ml labeled to be used for the resident. The medication had not been pulled for destruction or destroyed per facility policy and remained in the facility 387 days after the resident was discharged. 3. Review of Resident #102's physician orders, dated 5/23/23, showed no orders for Heparin Lock Flush Solution 100 Unit/ml (a blood thinner that prevents the formation of blood clots. Heparin flush is used to flush an intravenous (IV) catheter (indwelling single-lumen plastic conduit that allows medications to be introduced directly into a peripheral vein) which helps prevent blockage in the tube after an individual receives an IV infusion (a method to put medications into the blood stream). Review of the facility clinical census showed the resident was discharged on 6/02/23. Observation on 4/02/24 at 4:00 P.M., of the lower level medication storage room, in the lower middle cabinet, showed the following medications labeled for the resident: -Nine Heparin Lock Flush Solution 100 unit/ml; -One normal saline flush 0.9 percent solution 3 ml	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 10	F 761		

(this product is used to help prevent IV catheters from becoming blocked and also to help remove any medication that may be left where the IV is placed through the skin);
-One normal saline flush 0.9 percent solution 12 ml.

The medications had not been pulled for destruction or destroyed per facility policy and remained in the facility 306 days after the resident was discharged.

4. Review of Resident #103's physician orders, dated 8/04/23, showed no orders for Heparin Lock Flush Solution 100 unit/ml.

Review of the facility clinical census showed the resident was discharged on 9/14/23.

Observation on 4/02/24 at 4:00 P.M., of the lower level medication storage room, in the lower middle cabinet, showed 70 Heparin Lock Flush Solution 100 Unit/ml, labeled for the resident.

The medication had not been pulled for destruction or destroyed per facility policy and remained in the facility 202 days after the resident was discharged.

5. Review of Resident #104's physician orders, dated 11/03/23, showed NovoLog Flex Pen subcutaneous solution pen-injector 100 unit/ml.

Review of the facility clinical census showed the resident was discharged on 11/06/23.

Observation on 4/02/24 at 4:00 P.M., of the refrigerator in the lower level medication storage room, showed an unopened NovoLog Flex Pen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11 subcutaneous solution pen-injector 100 unit/ml, labeled for the resident. The medication had not been pulled for destruction or destroyed per facility policy and remained in the facility 149 days after the resident was discharged. 6. Review of Resident #105's physician orders, dated 11/15/23, showed no orders for BD PosiFLush injection 0.9 percent (saline flush). Review of the facility clinical census showed the resident was discharged on 11/30/23. Observation on 4/02/24 at 4:00 P.M., of the lower level medication storage room, in the right lower cabinet, showed ten BD PosiFLush injection 0.9 percent (saline flush), labeled for the resident. The medication had not been pulled for destruction or destroyed per facility policy and remained in the facility 125 days after the resident was discharged. 7. Review of Resident #106's physician orders, dated 11/02/23, showed no orders for insulin glargine (injectable medication to lower blood sugar) 100 unit/ml and Heparin Lock Flush Solution 100 unit/ml. Review of the facility clinical census showed the resident was discharged on 12/01/23. Observation on 4/02/24 at 4:00 P.M., of the lower level medication storage room showed the following: -One open bottle of insulin glargine 100 unit/ml labeled for the resident;	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 -Twelve Heparin Lock Flush Solution 100 unit/ml labeled for the resident. The medications had not been pulled for destruction or destroyed per facility policy and remained in the facility 124 days after the resident was discharged. 8. Review of Resident #107's physician orders, dated 2/19/24, showed the following: -Glucagon Emergency Kit (medication to treat severe low blood sugar) which included glucagon 1 mg vial and the diluent; -Naloxone hydrochloride (HCl) (used along with emergency medical treatment to reverse the life-threatening effects of a known or suspected opiate (narcotic) overdose) injections solution 0.4 mg/ml. Review of the facility clinical census showed the resident was discharged on 2/23/24. Observation on 4/02/24 at 4:00 P.M., of the lower level medication storage room, in the upper middle cabinet, showed one Glucagon Emergency Kit and six Naloxone hydrochloride (HCl) injections, labeled for the resident. The medications had not been pulled for destruction or destroyed per facility policy and remained in the facility 40 days after the resident was discharged. 9. Observation on 04/02/24 at 4:00 P.M. showed the following medications were found in the upper middle cabinet of the lower medication room and were unlabeled (not labeled for any specific resident): -Nine Glucose 5 oral glucose gel (to treat low	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 13 blood sugar levels); -One Glucagon Emergency Kit. Observation on 4/02/24 at 4:00 P.M. showed the following medications were found in the refrigerator, in the lower level medication room, and were unlabeled (not labeled for any specific resident): -Two vials of lorazepam 2 mg/ml (There was no narcotic control count log attached and no evidence staff reconciled the medication every shift); -Two vials of Solu-Medrol (steroid for inflammation) 40 mg; -23 acetaminophen 650 mg suppositories; -67 Bisacodyl 10 mg suppositories; -One Glucagon Emergency Kit; -53 acetaminophen 650 mg suppositories; -118 bisacodyl 10 mg suppositories; -Ten loperamide hydrochloride (anti-diarrheal) 2 mg; -Four ondanestron (nausea) disintegrating tablets 2 mg; -Two dairy relief (help to digest dairy products) 9000 Foods Chemical Codex (FCC) lactase units. During an interview on 4/03/24 at 12:30 P.M., Licensed Practical Nurse (LPN) J said there were no stock medications stored in the lower level medication room. During an interview on 4/02/24 at 4:00 P.M., Registered Nurse (RN) M said the facility does not keep stock medications in the lower level medication room. 10. Observation on 4/03/24 at 12:30 P.M., showed the following: -Licensed Practical Nurse (LPN) J had removed	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 14	F 761		

pharmacy pill packs of medications (for an unknown resident) from the active medication cart;
-LPN J was destroying the medications using the Drug Buster medication disposal system (quickly turns most non-hazardous medications into a non-toxic slurry (change the tablet form of a medication to a liquid) that can be safely put in the trash);
-LPN J was by his/herself; there were not two licensed staff destroying medications together as facility policy instructed.

During an interview on 4/03/24 at 12:30 P.M. and 4/11/24 at 4:55 P.M., LPN J said the following:
-The only time medication were stored in the lower level medication room, was if a resident who was out of the facility, like at the hospital, and the resident was expected to return to the facility;
-When a resident was discharged from the lower level, the nurse was responsible to destroy the resident's medications;
-The medications he/she destroyed by himself/herself were extra medications sent from the pharmacy. These medications belonged to discharged residents;
-He/She destroyed one tablet of aspirin 81 mg, senna 8.6 mg (medication to treat constipation), levothyroxide (thyroid medication) 50 micrograms (mcg) and finasteride (prostate medication) 5 mg;
-He/She used the Drug Buster medication disposal system;
-The medications he/she destroyed were not narcotics and did not need another licensed staff as a witness;
-He/She did not document the medications destroyed;
-He/She was not aware of a facility policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15 requiring two licensed staff being needed to destroy medications; -There was no stock medications stored in the lower level medication room. 11. During an interview on 4/02/24 at 4:00 P.M., Registered Nurse (RN) M said the following: -The nurses who worked on the lower level were responsible for maintaining the medication storage room on the lower floor; -The nurse discharging a resident was responsible for discarding medications when a resident was no longer a resident in the facility; -There was no specific time frame which medications were destroyed; -There was no specific policy or protocol for the medication destruction on the lower level of the nursing facility; -The lorazepam vials should not have been in the refrigerator. If a narcotic has to be refrigerated, it should be kept in a locked box in the refrigerator; -He/She could not recall who any of the unlabeled medications belonged to. During an interview on 4/03/24 at 2:30 P.M., 4/04/24 at 11:35 A.M. and 4/15/24 at 4:07 P.M., the DON said the following: -There should be no medications for discharged residents in the lower level medication room; -When a resident is discharged, two nurses should destroy the resident's medications; -When a resident is discharged, the facility has 30 days to destroy the medication; -Lorazepam 2 mg/IM should not be stored in an unlocked refrigerator; it should be in a lock box in the refrigerator; -A private contracted pharmacy consultant checked the medication storage room located in the lower level;	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16 -The pharmacy consultant checked the facility's medication rooms every month, as well as quarterly, for medications that need to be destroyed; -The last two times the pharmacy consultant checked the lower level medication storage room was on 3/06/24 and 4/12/24 and there were no reported medications that needed to be destroyed; -She was unaware there were any medications in the lower level medication storage room that needed to be destroyed; -There were no medications in the DON's office waiting to be destroyed. During an interview on 4/15/24 at 4:25 P.M., the administrator said the following: -She expected staff to destroy medications after a resident was discharged; -She would not expect medications to be in the lower level storage room for 671 days, 387 days, 306 days, 202 days, 149 days, 125 days, 124 days, or 40 days; -The pharmacy consultant checked the medication rooms each month and sends a report to the facility of medication which need to be destroyed; -She was unaware there were medications in the lower level storage room which needed to be destroyed; -She would expect a narcotic to placed in a lock box in the refrigerator, if the medication needed to be refrigerated.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety and sanitation. Staff failed to practice proper hygienic practices, including hair restraint use, handwashing and gloving, and consumption of personal food and beverage items, when preparing and serving food to residents. Staff failed to ensure food and beverage containers and utensils were handled in a sanitary manner and were protected from moisture and other contaminants. Staff failed to ensure food items were in good condition and were sealed, labeled, dated, and stored in accordance with the manufacturer's label. Staff failed to ensure resident food items, including items located in a unit refrigerator outside of the kitchen, were stored under sanitary conditions. Staff also failed to ensure the ice machine and ceiling vent were clean to prevent potential	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 18	F 812		

contamination to food preparation and dish storage areas. The facility census was 46.

1. Review of the facility's policy, Personal Hygiene Policy, dated 6/2/21, showed the following:
-Employees are expected to maintain the highest standard of personal cleanliness and present a neat, professional appearance at all times;
-Facial hair that is longer than chin length must be secured away from the face;
-All dietary staff are required to wear hair nets or a head covering to keep hair out of their face to maintain a sterile environment for all persons;
-All persons with facial hair must wear a beard guard at all times while in the kitchen.

Observation on 4/1/24 at 11:07 A.M., of the kitchen wall by the dining room door entrance, showed a black holder with a sign that read, "Hairnets, All Hair Must Be Covered."

Observation on 4/1/24 at 12:42 P.M., in the kitchen, showed the following:
-Dietary Aide E prepared food items at the food preparation area for the lunch meal service;
-He/She poured margarine into a pan of noodles, stirred the noodles and margarine, and brought it to the serving area;
-He/She then poured milk into a food processor of dessert to make a pureed dessert and scooped the dessert into individual bowls;
-He/She had 0.5-inch long facial hair that covered approximately 40% of his/her face;
-He/She did not wear a beard restraint.

Observation on 4/1/24 at 12:52 P.M., in the kitchen, showed the following:
-At the beverage preparation counter, located inside the kitchen and near the food preparation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 19 and serving counters, Certified Nurse Assistant (CNA) G prepared beverages for residents; -He/She poured beverages into cups, added contents from individual packets into the cups, and stirred the beverage contents in the cups; -He/She wore a hairnet but his/her hair was not completely covered by the hairnet; -Two-inch sections of exposed hair hung down on each side of his/her face. Observation on 4/1/24 at 1:33 P.M., in the kitchen, showed the following: -The dietary manager served food onto seven resident's trays that were spread out on the food preparation counter; -Dietary Aide D leaned over the opposite side of the counter, approximately one foot away from the trays of food, and read the facility's recipe binder; -Dietary Aide D had one-inch long facial hair that covered approximately 40% of his/her face; -He/She did not wear a facial hair/beard restraint. During an interview on 4/2/24 at 1:16 P.M., the dietary manager said she expected staff to wear hair and beard restraints when working in the kitchen and for staff to wear the hair/beard restraints properly. 2. Review of the facility's policy, Hand Washing and Glove Use, dated 10/20/19, showed the following: -Hand washing is a priority for infection control; -Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substances (i.e. raw chicken to fresh fruit), following contact with any unsanitary surface (i.e. touching hair, sneezing,	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 20 opening doors); -Washing procedure: wet hands, apply soap, lather vigorously rubbing hands together for approximately 11 seconds, rinse hands to remove soap and debris, dry hands with a disposable paper towel, discard of paper in a foot pedal trash can; -Gloves may be used when working with food to avoid contact with hands, gloves must be worn when touching any ready-to-eat food; -When gloves are used, hand washing must occur per above procedure prior to putting on gloves and whenever gloves are changed; -Gloves must be changed as often as hands need to be washed, gloves may be used for one task only; -Gloves can often give a false sense of security and can carry germs same as our hands. Observation on 4/1/24 from 12:20 P.M. to 12:44 P.M., in the kitchen, showed the following: -The dietary manager used her gloved hands to grasp the handles of utensils to serve food onto resident plates during the lunch meal service; -With her same gloved hands, she used potholders to obtain additional pans of food items from the convection oven, placed the pans into the countertop steam table, uncovered the foil on the pans, used a thermometer to take the temperature of the food items, and used an alcohol preparation pad to clean the thermometer probe; -She then opened the utensil drawer, obtained serving utensils, placed the utensils in the pans of food at the steam table, and continued serving resident's plates; -She removed her gloves and used potholders to obtain additional items from the convection oven, used the thermometer to take the temperature of	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21	F 812		

the food items, and used an alcohol pad to clean the thermometer probe;
-She flipped through pages of a binder (located on the food preparation counter), then opened the utensil drawer, obtained a scoop, and placed the scoop in a food item on the steam table;
-She opened the utensil drawer again then closed it without obtaining any utensils;
-Without washing her hands, she obtained a clean plate and touched the top eating surface of the plate and continued serving residents' plates;
-She grasped a cabinet handle to obtain two cans of soup and opened one of the cans of soup;
-She poured the soup into a bowl, placed the soup into the microwave by grasping the microwave handle and pushed buttons on the microwave to turn it on;
-She continued serving resident's plates, then obtained serving utensils from the utensil drawer and walked across the kitchen to place the utensils on the portable food cart headed to the lower level dining room;
-She obtained two small plates from a cabinet (located across the kitchen by the ice machine), brought the plates to the serving area, placed the warmed bowl of soup from the microwave onto one plate to serve to a resident, and prepared the second bowl of soup in the microwave.

Observation on 4/1/24 at 12:45 P.M., in the kitchen, showed the following:
-Dietary Aide E was in the dishwashing area and wore gloves on his/her hands;
-He/She adjusted his/her pants and walked into the food preparation area;
-He/She opened the utensil drawer by the handle, grasped a measuring spoon by the food contact surface, returned the spoon to the drawer, and closed the drawer;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 22 -He/She touched the surface of the food preparation counter, walked into the dishwashing area, and closed the door of the dishwashing machine to start a new load of dishes; -He/She discarded his/her gloves, did not wash his/her hands, and donned new gloves; -He/She grabbed a small stack of laminated resident meal cards from on top of the dishwashing machine, carried them to the serving area across the kitchen, and spread out the meal cards on the counter; -He/She removed his/her gloves, opened the convection oven door handle and used a white cloth as a potholder to obtain a pan of noodles; -He/She did not wash his/her hands and donned new gloves; -Using his/her gloved hands, he/she poured milk from a jug into a measuring cup and added it to the food processor to prepare a pureed food item. Observation on 4/1/24 at 12:56 P.M., at the kitchen serving area, showed the following: -CNA G leaned over and rested his/her bare hands on his/her face and mouth on the dining room side of the food serving counter; -Without washing his/her hands, he/she then used his/her bare hands to carry and serve plates of food and cups of desserts to residents in the dining room. Observation on 4/1/24 from 12:59 P.M. to 1:18 P.M., in the kitchen and adjacent dining room, showed the following: -The dietary manager used her bare hands to open the convection oven, use a thermometer to take the temperature of noodles in a pan, and sanitize the thermometer probe with an alcohol pad; -She used a silicone plate gripper to carry the pan	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 of noodles to the serving area and used a scoop to serve noodles onto a resident's plate; -She used tongs to carry a piece of chicken from the countertop steam table to a cutting board on the preparation counter, cut the chicken into pieces, and placed the chicken on the plate with the noodles; -She served other food items onto the plate and carried the plate of food to a resident in the dining room; -She re-entered the kitchen, did not wash her hands, and used her bare hands to obtain a lid and placed it on the countertop steam table; -She touched and rearranged laminated resident meal ticket cards on the serving counter, touched the handles of serving utensils located in food items at the countertop steam table, and carried dirty dishes to the dishwashing area; -She opened the reach-in refrigerator and placed a food item inside, used an ink pen to write on the paper temperature log located on the refrigerator, and wiped down a tray cart with a white cloth and spray from a spray bottle in the dishwashing area; -She did not wash her hands and walked from the dishwashing area to the preparation area with a stack of clean black trays and laid them out on the counter; -She placed resident meal cards and wrapped silverware onto the trays; -She covered bowls of dessert with plastic wrap and placed the wrapped bowls on the trays. Observation on 4/1/24 at 1:24 P.M., in the kitchen, showed the following: -The dietary manager washed her hands at the handwashing sink, rubbed her nose with her clean hands, and did not discard the paper towel she used to dry her hands; -While she carried the used paper towel in her	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 24	F 812		

right bare hand, she picked up clean plate bases with both hands and put the bases on the preparation counter;
-She carried three plate covers to the dirty side of the dishwashing area, pulled down the door of the dishwashing machine, and started the dishwashing machine;
-She stopped at the handwashing sink (she did not wash her hands) and used the paper towel she was carrying to turn off the handwashing sink faucet handle and discarded the paper towel;
-She obtained additional clean plate covers and placed them on the trays on the preparation counter;
-She served food items onto residents' plates, placed the food plates on the trays, and put the plate covers on the plates to be served to residents on the halls.

During an interview on 4/2/24 at 1:06 P.M., Dietary Aide F said staff should wash their hands constantly, such as before handling clean dishes and utensils, after completing dirty tasks, or when changing tasks.

During an interview on 4/2/24 at 1:16 P.M., the dietary manager said staff should wash their hands frequently, such as when entering the kitchen, after completing dirty tasks or touching unsanitary items (i.e. door handles, items dropped on the floor), between glove changes, prior to handling clean utensils and dishes. Changing staff's gloves did not substitute the need for staff to wash their hands.

3. Review of the facility's policy, Staff Food and Drink Policy, dated 3/4/21, showed the following:
-Dietary staff will keep all personal items including food and drink in the office area;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25 -Dietary staff will consume food and beverages in the office area, no personal items will be stored or consumed near food production areas or food storage areas. Observation on 4/1/23 at 1:14 P.M., in the kitchen, showed the following: -A bottle of soda sat near a tray of clean mugs located in the beverage preparation counter; -Dietary Aide F picked up the bottle, took a drink from the bottle, and sat the bottle back on the counter; -He/She did not wash his/her hands after drinking from the bottle; -He/She touched and leaned on the beverage preparation counter. During an interview on 4/2/24 at 1:06 P.M., Dietary Aide F said staff should store personal beverage items in the dietary manager's office. During an interview on 4/2/24 at 1:16 P.M., the dietary manager said staff should store and use their personal items, such as beverages and phones, in the dietary manager's office and wash their hands after using personal items. 4. Review of the facility's policy, Dish and Utensil Procedure, dated 5/28/20, showed the following: -Spoons, knives, and forks shall be touched only by their handles; -Cups, glasses, bowls, and plates shall be handled without contact with inside surfaces or surfaces that contact the user's mouth; -Dishes and utensils shall be handled with clean hands; -Dishes and utensils shall be air dried before storage.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26 Review of the facility's policy, Dish Handling and Dish Storage Policy, dated 2/14/21, showed the following: -Dietary staff will use ensure dishes are clean and dry before putting them into the storage areas while using clean hands; -Dietary staff will ensure that serving utensils are handled by handles only; -Dietary staff will ensure silverware is handled by the handles while transferring into the silverware container or being rolled up in a napkin for service; -Dietary staff will ensure cups, glasses, bowls, and plates are handled without touching the inside surfaces or the surface that contact users mouths. Observation on 4/1/24 at 11:48 A.M., in the kitchen, showed the following: -CNA G entered the kitchen with a cart of approximately 20 pink plastic handled cups with lids; -He/She did not wash his/her hands upon entering the kitchen; -With his/her bare hands, he/she removed lids from the cups and placed the lids on the cart, emptied water from the cups into the food preparation counter sink, and filled the cups with new water from the sink faucet; -He/She dropped a cup lid on the floor, picked it up, rinsed the cup lid with water at the sink faucet, and placed the lid back on the cart with the other lids; -He/She did not wash or sanitize the dropped cup lid nor did he/she wash his/her hands after he/she picked up the lid from the floor; -Using his/her bare hands, he/she continued preparing drinks and grasped the cup lids and cups by the upper exterior drinking surfaces;	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 27 -He/She used a scoop from the ice machine to fill the cups of water with ice; -As he/she filled the cups of water with ice, he/she held the cups at an angle over the exposed ice machine bin that held fresh ice; -He/She positioned his/her left index finger on the upper interior drinking surface of the cups and some of the ice spilled from the cup of ice and water back into the ice machine bin; -When he/she returned the ice scoop to the ice machine's interior slot, his/her bare hand touched the surface of the fresh ice in the machine bin; -He/She took the lids from the cart (which included the lid that had been dropped on the floor) and put them back onto the cups. Observation on 4/1/24, in the kitchen, showed the following: -At 12:04 P.M., Dietary Aide F used his/her bare hands to move clean silverware from a green upright dishwashing utensil holder to a brown horizontal divided silverware tray. As he/she moved the silverware, he/she touched the eating surfaces of the silverware; -At 12:55 P.M., Dietary Aide F used his/her bare hands to grab silverware from the brown divided tray, place the silverware onto napkins, and wrap the silverware inside the napkins. As she moved and wrapped the silverware, he/she touched the eating surfaces of the silverware. Observation on 4/2/24 at 12:26 P.M., in the kitchen, showed the following: -Dietary Aide D used his/her bare hands to move clean silverware from a blue flat dishwashing utensil tray to a brown horizontal divided silverware tray; -As he/she moved the silverware, he/she touched the eating surfaces of the silverware;	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 28 -Several drops of water dripped from the silverware as he/she moved it from the flat tray to the divided tray. Observation on 4/2/24 at 1:18 P.M., in the kitchen, showed the following: -A stack of inverted trays sat under the serving counter; -The top tray had dried brown food debris on the corner of the tray's inverted surface; -Dietary Aide E placed a clean tray (inverted) on the stack of trays; -The clean tray was visibly wet on all sides and the foodware contact surface of the tray touched the dried brown food debris (located on the previous top tray). During an interview on 4/2/24 at 1:06 P.M., Dietary Aide F said staff should handle utensils by their handles and cups, glasses, and dishes by their sides or bottoms. During an interview on 4/2/24 at 1:16 P.M., the dietary manager said the following: -If staff drop a cup lid on the floor, staff should ensure it is washed and sanitized before using it. Rinsing the cup lid under water would not be sufficient to clean/sanitize the item; -Staff should handle utensils and food/beverage items by the non-eating and non-food contact surfaces (i.e. handles, bottoms, and sides) of the items; -Food and beverage ware should be stored clean and dry. 5. Review of the facility's policy, Food Storage, dated 10/20/19, showed the following: -Food items will be stored, thawed, and prepared	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 29 in accordance with good sanitary practice; -All products shall be dated upon receipt or when they are prepared; -Use date shall be marked on all food containers according to the timetable in the Dry, Refrigerated, and Freezer Storage Chart. Observation on 4/1/24 at 11:07 A.M., in the kitchen, showed the following: -Two open 17.5-pound containers of liquid margarine sat unrefrigerated on the shelf below the food preparation counter near the dry spice storage area; -The label of each container read: "Refrigerate for Best Quality." Observations on 4/1/24 at 11:07 A.M., 11:58 A.M., and 1:16 P.M., in the kitchen, showed the following: -An 8.5-ounce pouch of microwavable rice sat open on top of the microwave near the serving counter; -The pouch was approximately one-third full and the top edge was loosely folded over; -The label of the pouch read, "Refrigerate Unused Portion;" -No staff were observed in the area nor were actively using the food item. Observation on 4/1/24 at 2:25 P.M., in the lower level dining room, showed the following: -The freezer portion of the refrigerator contained three unlabeled and undated Styrofoam cups of an ice cream-like substance, two 18-ounce bags of hot dog buns with an excessive amount of ice crystal buildup visible on the buns, and one unopened 20-ounce can of pineapple chunks. The label on the pineapple can read 'Do Not Freeze' and the can was bulging slightly at the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 30 bottom of the can; -A wadded paper towel was visible on the bottom floor of the freezer; -The refrigerated portion contained six various colored liquids in unlabeled and undated beverage pitchers, an open half-full 33.8-ounce box of orange juice concentrate that was not marked with an open date or sealed to the air, and an open half-full 12-ounce bottle of soda (on a shelf that read 'Residents Only;' -A 12-inch by 12-inch section of dried brown residue was visible on the bottom floor of the refrigerated portion; -The cabinets contained a clear plastic container of brown sugar with a disposable spoon inside and touching the food contents, a half-full opened 18-ounce strawberry lemonade powder with no open date and was unsealed to air, a Styrofoam cub with light pink powder that was unlabeled and undated, a stack of unlabeled and undated cookies that was loosely wrapped with plastic wrap (25% of the food item was exposed to air), two half-full open bags of potato chips loosely folded over with one bag's 'Use Product By' date of 3/26/24; -The exterior handles of the refrigerator felt sticky to the touch; -The entire surface of the floor, located in front of the refrigerator and cabinets, was sticky. During an interview on 4/2/24 at 1:16 P.M., the dietary manager said the following: -She expected staff to store food items according to the manufacturer's food label; -Spoons and scoops should not be stored inside food storage bins. -She monitored the lower-level dining room refrigerator and cupboards on a weekly basis to ensure food was properly stored, labeled, and	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 31	F 812		

dated;
-She cleaned the lower-level dining room refrigerator monthly and also expected staff to clean it if they found that it was dirty;
-She was unaware of the can of pineapple located in the freezer in the lower level dining room refrigerator.

6. Review of the facility's policy, Ice Machine and Equipment Policy, dated 6/2/21, showed the following:
-The ice machine and equipment will be cleaned out completely semi-annually to maintain a clean and sanitary condition. Clean the exterior of the machine with a detergent solution, rinse, and allow to air dry;
-The exterior of the machine should be cleaned weekly using a sanitizing solution;
-Follow the manufacturer's cleaning and sanitizing instructions if available.

Observation on 4/1/24 at 11:07 A.M., in the kitchen, showed several dried white drips and a moderate accumulation of brown and white crusty debris on the left exterior surface of the ice machine.

During an interview on 4/2/24 at 1:16 P.M., the dietary manager said she cleaned the ice machine's exterior surface once a week but the encrusted deposits came back quickly and thought it might need to be cleaned with a calcium, lime, and rust cleaner. Staff cleaned and sanitized the interior and exterior of the machine every six months.

7. Observation on 4/2/24 at 8:30 A.M., of the kitchen ceiling above the dishwashing machine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265875	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	**3801 MCCLAY ROAD SAINT PETERS, MO 63376**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 32 and clean dish storage area, showed an approximate 20-inch by 20-inch ceiling vent was coated with a heavy accumulation of brown fuzzy debris. During an interview on 4/2/24 at 1:16 P.M., the dietary manager said dietary staff last cleaned the dishwashing machine ceiling vent about three months ago.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29933A	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II Refer to F760	A4055		
A4067	19 CSR 30-85.042(58) Meds Destroyed Within 30 Days All non-unit doses and all controlled substances which have been discontinued must be destroyed on the premises within thirty (30) days. Outdated, contaminated, or deteriorated medications and non-unit dose medications of deceased residents shall be destroyed within thirty (30) days. Unit dose medications returnable to the pharmacy shall be returned within thirty (30) days. II/III This regulation is not met as evidenced by: Class II* Refer to F761 *The higher classification merited due to the extent of the violation.	A4067		
A4068	19 CSR 30-85.042(59) Med Destruction-Required Staff Medications shall be destroyed in the facility by a pharmacist and a licensed nurse or by two (2) licensed nurses. III This regulation is not met as evidenced by:	A4068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29933A	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4068	Continued From page 1 Class III Refer to F761	A4068		
A4069	19 CSR 30-85.042(60) Med Destruction Record Facilities shall maintain records of medication destroyed in the facility. Records shall include: the resident's name; the date; the name, strength, and quantity of the medication; the prescription number; and the signatures of the participating parties. III This regulation is not met as evidenced by: Class III Refer to F761	A4069		
A4071	19 CSR 30-85.042(62) Controlled Substance Reconcile/Record The facility must establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The system must enable the facility to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled. II/III This regulation is not met as evidenced by: Class III Refer to F761	A4071		
A4092	19 CSR 30-85.042(83) Equip Sanitized/Stored, Prevent Contamination Facilities shall keep all utensils and equipment in good condition, effectively sanitized, sterilized, or	A4092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29933A	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4092	Continued From page 2 both, and stored to prevent contamination. II/III This regulation is not met as evidenced by: Class II Refer to F880	A4092		
A7002	19 CSR 30-87.030(2) Wash Hands/Arms & Clean Fingernails Employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as is necessary to keep them clean and after smoking, eating, drinking or using the toilet. Employees shall keep their fingernails clean and trimmed. II/III This regulation is not met as evidenced by: Class II* Refer to F812 *The higher classification merited due to the extent of the violation.	A7002		
A7003	19 CSR 30-87.030(3) Clean Clothing, Hair Restraints The outer clothing of all employees shall be clean and employees shall use effective hair restraints to prevent the contamination of food or food-contact surfaces. III This regulation is not met as evidenced by: Class III Refer to F812	A7003		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29933A	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7015	Continued From page 3	A7015		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class II* Refer to F812 *The higher classification merited due to the extent of the violation.	A7015		
A7064	19 CSR 30-87.030(62) Kitchenware/Surfaces/Pitchers-Clean/Sanitize Kitchenware and food-contact surfaces of equipment shall be washed, rinsed and sanitized	A7064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29933A	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7064	Continued From page 4 after each use and following any interruption of operations during which time contamination may have occurred. Water pitchers which are for individual resident use shall be sanitized daily. II/III This regulation is not met as evidenced by: Class II* Refer to F812 *The higher classification merited due to the extent of the violation.	A7064		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Refer to F812	A7067		
A7086	19 CSR 30-87.030(84) Equip/Utensils Air Dried, Self-Drain Utensils After mechanical or manual sanitization, all equipment and utensils shall be air dried. All utensils shall be stored in a self-draining position. III This regulation is not met as evidenced by: Class III Refer to F812	A7086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29933A	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCLAY SENIOR CARE	3801 MCCLAY ROAD SAINT PETERS, MO 63376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7087	19 CSR 30-87.030(85) Protect Equipment/Utensils From Contamination Cleaned and sanitized equipment and utensils shall be handled in a way that protects them from contamination. Spoons, knives and forks shall be touched only by their handles. Cups, glasses, bowls, plates and similar items shall be handled without contact with inside surfaces or surfaces that contact the user ' s mouth. III This regulation is not met as evidenced by: Class III Refer to F812	A7087		

PLAN OF CORRECTION

Provider/Supplier Name:	McClay Senior Care Provider #: 265875
Street Address, City, Zip:	3801 McClay Road St. Peters, Mo 63376
Date of Survey:	Survey Completed 04/04/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	5/17/2024
F760	Facility failed to ensure residents #3, #5, #44 were free from significant medication errors. Staff failed to prime (remove the air) the Humalog/Novolog Kwik pen (prefilled pen of fast acting insulin) (medication injected under the skin used to treat diabetes) needle as instructed by the manufacturer prior to administration of the medication, resulting in administration of less than the ordered dose of Humalog/Novolog. Staff failed to hold the needle against the resident's skin for the manufacturer's suggested time after the administration of medication. Corrections for cited examples include: • Facility will follow manufacturers instructions to prime insulin • Resident #5 has received primed insulin by qualified staff holding the insulin for 5 seconds before removing the needle tip from the skin. • Resident #44 has received primed insulin by qualified staff holding the insulin for 5 seconds before removing the needle tip from the skin. • Resident #3 has received primed insulin by qualified staff holding the insulin for 5 seconds before removing the needle tip from the skin.	5/17/2024

F760	The facility will identify other situations having the potential to be affected by the same deficient practices as follows: • All diabetic residents will be considered at risk for the alleged deficient practice. The measures that will be put into place of systematic changes made to ensure that the deficient practice will not recur are as follows: • Facility designees will in-service staff on proper insulin priming procedures according to manufacturer and facility policy. • Facility designee will audit 3 random residents 2 times for 3 weeks then randomly ongoing. • Residents #3, #5, #44 will be audited 4 times per week for 3 weeks and then randomly ongoing. • Any deficient practices will be remedied immediately. • These remedies will be reviewed at the next (2) QAPI meetings to ensure compliance is maintained. QAPI meetings are held monthly. • New hires will be trained upon orientation and any concerns will be brought to nursing management and remedied immediately.	5/17/2024
F761	Facility failed to ensure labeling/storage of all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Facility failed to provide a double locked system for storage of controlled drugs listed in Schedule II in the refrigerator. The facility failed to remove and destroy discharged resident medications from the lower level medication room for eight discharged residents (#100,#101,#102,#103,104,#105,#106, and #107) as directed by facility policy. The measures that will be put into place of systemic changes made to ensure that the deficient practice will not occur are as follows: • Facility staff administering medications will be in-serviced by facility designee regarding proper label/storage of all drugs and biologicals. • Facility designee will ensure a separate lock box is available in the unit's locked medication room refrigerator.	5/17/2024

F761	• Facility designee will ensure that narcotics/controlled substances will be stored under a double locking system; kept in the locked box in the unit's locked medication storage accompanied by a narcotic sheet. • Medication destruction binder with logs are kept in the medication rooms overseen by the facility designee. • Medications are destroyed at least every 30 days per facility policy. • Discharged residents medications have been removed and destroyed in accordance with facility policy. • Facility policy has been updated to say that medication storage and destruction will take place in the medication rooms with 2 nurses at least every 30 days. • Facility designee will conduct an audit two times weekly of medication storage in medication rooms, medication carts, refrigerators and locked systems. • Facility designee will ensure that all stored medications are properly labeled with resident's name, medication name, amount, dose and strength, date dispersed to facility and if applicable a sheet with lines to record each dose removed, date, time, and signature. • Resident #100, #101, #102, #103, #104, #105, #106, #107, have been discharged from the facility and their medication has been destroyed. • Narcotics that need to be refrigerated are stored in a lock box in the medication room. The measures that will be put into place of systemic changes to ensure that the deficient practice will not recur are as follows: Corrections for cited examples include: • Inservice education-by facility designee regarding proper medication destruction process of all medications and biologicals. • Staff in-serviced on proper storage and labeling of medications. • Medication room audits to be performed by Facility designee two times per week to assure compliance with facility policy. • Narcotics are stored under a double locking system. A lock box will be kept in the rehab fridge for narcotics. The medication room is locked. • Narcotics that are discontinued/or on resident discharged to be counted/cataloged and destroyed by 2 facility nurses within 30 days.	5/17/2024

F761	• Medications are disposed of in a chemical solution (Drug Buster) Container is then placed in the trash. • The DON will maintain the records of the medication destruction logs. • These remedies will be reviewed at the next (2) QAPI meetings. Meetings are held monthly. • Any issues will be remedied immediately.	5/17/2024
F812	The facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety and sanitation. Staff failed to practice proper hygienic practices, including hair net restraint, handwashing and gloving, and consumption of personal food and beverage items, when preparing and serving food to residents. Staff failed to ensure food and beverage containers and utensils were handled in a sanitary manner and were protected from moisture and other contaminants. Staff failed to ensure food items were in good condition and were sealed, labeled, dated, and stored in accordance with the manufacturer's label. Staff failed to ensure resident food items, including items located in a unit refrigerator outside of the kitchen, were stored under sanitary conditions. Staff also failed to ensure the ice machine and ceiling vent were clean to prevent potential contamination to food preparation and dish storage areas. Corrections for cited examples include; • Dietary Manager ensures that hairnets are worn and beard nets are worn for chin length hair or longer at all times in the kitchen. • Any personal food and beverage were removed from the kitchen and only in the designated storage area to be consumed. • Dietary staff have been in-serviced about facility policy regarding wear hair nets and beard nets • Hair nets and beard nets are located at the entrance of the kitchen. • Dietary department was in-serviced on proper glove usage and hand sanitation practices for handling of dishware in	5/17/2024

	accordance with facility policy to protect from moisture and other contaminants. • All food items are stored, labeled, and dated in accordance with the manufacturer's label. Including food/drink storage in the lower level rehab kitchenette, and refrigerator and freezer. • Any food items that were not in good condition and were not sealed, labeled, dated, or stored in accordance with manufacturers label have been thrown in the trash. • Rehab Kitchenette is cleaned daily after meals by housekeeping staff. • Any items stored in the rehab kitchenette, rehab refrigerator/freezer, that were stored under unsanitary conditions have been thrown in the trash. • Dietary manager checks rehab kitchenette weekly to ensure compliance. • Ice machine is cleaned weekly per cleaning schedule and as needed. • Ceiling vent was cleaned per cleaning schedule and as needed. • Dietician in-serviced Dietary Manager and dietary personnel on proper glove usage.	
F812	The facility will identify other situations having the potential to be affected by the same deficient practice as follows: • All residents will be considered at risk for the alleged deficient practices. The measures that will be put into place of systematic changes made to ensure that the deficient practice will not recur are as follows: • Dietician has in-serviced Dietary Manager and staff on proper gloving and sanitation • Dietary manager will inservice staff on proper food storage, labeling and dating. • Dietary Manager will in-service staff on handling clean dishware and audit 3 times weekly for 3 weeks and then randomly on-going. • Dietary manager will audit for proper sanitation 3 times weekly on different shifts for 3 weeks and then randomly on going. • The Dietary Manager will ensure proper glove usage and beard net usage on going indefinitely. • Dietary manager will audit for cleanliness of ceiling vent, ice bin, and dish storage area weekly for 3 weeks and then randomly on-going and as needed.	5/17/2024

F812	• These remedies will be reviewed at the next (2) QAPI meetings. Meetings are held monthly. • Any issues will be reported to the Administrator and remedied immediately.	5/17/2024

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	McClay Senior Care Provider Number # 265875
Street Address, City, Zip:	3801 McClay Road Saint Peter's Missouri 63376
Date of Survey:	Survey completed 04/04/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265875

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4055	Refer to F760	5/17/2024
A4067	Refer to F761	5/17/2024
A4068	Refer to F761	5/17/2024
A4069	Refer to F761	5/17/2024
A4071	Refer to F761	5/17/2024
A4092	Refer to F880	5/17/2024
A7002	Refer to F812	5/17/2024
A7003	Refer to F812	5/17/2024
A7015	Refer to F812	5/17/2024
A7064	Refer to F812	5/17/2024
A7067	Refer to F812	5/17/2024
A7086	Refer to F812	5/17/2024
A7087	Refer to F812	5/17/2024

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.