STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265828	A. BUILDING _____ B. WING _____	C 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON GARDEN	4359 TAFT AVENUE SAINT LOUIS, MO 63116

(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 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		

§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide meaningful activities or one on one activities for residents dependent on staff for their needs, for four (Residents #27, #5, #28, and #33) of 31 sampled residents. The census was 55.

1. Review of the facility's March and April 2024 activity's calendar, included:
-3/28/24: 8:30 A.M., Coffee talk time; 11:30 A.M., Movie Lunch; 2:00 P.M., Resident Council and 5:00 P.M., cards;
-3/29/24: 8:30 A.M., Coffee talk time; 10:30 A.M., one on ones; 12:00 P.M., 70s/80s musical lunch; 2:00 P.M., Easter Party; 5:00 P.M., cards;
-3/30/24: 8:30 A.M., Coffee talk time; 1:00 P.M., coloring club; 5:00 P.M., cards;
-3/31/24: 8:30 A.M., Coffee talk time; 1:00 P.M., book club; 5:00 P.M., cards;
-4/1/24: 8:30 A.M., Coffee talk time; 12:00 P.M., 50s/60s musical lunch; 2:00 P.M., Resident council; 5:00 P.M., cards;
-4/2/24: 8:30 A.M., Coffee talk time; 11:30 A.M., movie lunch; 2:00 P.M., bible study; 5:00 P.M.,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/7/24

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.

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cards;
-4/3/24: 8:30 A.M., Coffee talk time; 10:30 A.M., one on ones; 12:00 P.M., pop musical lunch; 2:00 P.M., bingo; 5:00 P.M., cards.

2. Observation and interview during the Resident Group meeting on 4/1/24 at 10:15 A.M., showed five residents, who the facility identified as alert and oriented, attended the meeting. When asked about the facility's activity program, Resident #10 said activities are pretty much bingo. Resident #8 agreed and said the activities program should give us something to look forward to. Resident #45 said the activity program is not good, there is a Preacher who visits, sometimes a violin player, and a pastor comes here on Sundays. Resident #10 said he/she volunteers to lead the activities, and he/she also does the weekend activities. He/She said during activities, the residents play Monopoly, cards or bingo, otherwise, some residents read and some watch television. The activities are all done on their own. There was no regular activities program.

3. Review of Resident #27's Preference for Customary Routine and Activities, dated 12/5/23, showed:
-Resident to have books, newspapers and magazines to read-Somewhat important;
-Listening to music-Not important at all;
-No additional activity preferences.

Review of the resident's care plan, dated 12/12/2022, edited on 1/1/2024, showed:
-Problem: Activities, resident is not at ease in joining other residents in activities. He/She prefers to watch television like the news, he/she likes snacks from the vending machine;
-Goal: Resident will express satisfaction with

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activity involvement;
-Approach: Likes listening to music, encourage to express his/her preferences with activities.

Review of the resident's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/11/24, showed::
-Cognitively moderately impaired;
-Independent with activities of daily living (ADLs);
-Diagnoses included: Schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), heart disease, stroke and cancer.

During an interview on 4/3/24 at 9:00 A.M., the resident said if you like bingo, the activities program is okay. He/She wants to go outside, do something outside, walk around the block, anything. He/She couldn't recall the last time he/she did something outside, other than sit on the porch. He/She didn't know they had Bible study. He/She used to go church regularly, and would enjoy Bible study.

During an interview on 4/3/24 at 9:10 A.M., the Activities Director (AD) said the resident enjoys movies and has never talked about doing anything else.

4. Review of Resident #5's Preference for Customary Routine and Activities, dated 7/12/23, showed:
-Resident to have books, newspapers and magazines to read-Somewhat important;
-Listening to music-Very important;
-Be around animals and pets-Very important;
-Keep up with the news-Very important;
-Do things with groups of people-Not important at

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all;
-Do favorite activities-Very important;
-Go outside when good weather-Very important;
-Participate in religious practices-Somewhat important.

Review of the resident's activity's note, dated 11/20/23 at 12:28 P.M., showed talked with resident. Resident talked with me (Activity Director) about his/her tattoos.
-No further activity notes.

Review of the resident's quarterly MDS, dated 1/17/24, showed:
-Cognitively intact;
-No behaviors;
-Independent with mobility;
-Diagnoses included: Diabetes, anxiety, depression and schizophrenia.

Review of the resident's care plan, in use during the time of the investigation, last updated on 1/18/24, showed no information regarding activities.

During interviews on 3/28/24 at 1:03 P.M. and 4/2/24 at 8:00 A.M., the resident said he/she did not participate in activities because the facility did not offer many choices. They played bingo and card games on Monday, Wednesday and Friday. If the facility offered more activities, he/she would participate.

During an interview on 4/3/24 at 9:10 A.M., the AD said the resident did not enjoy activities. He/She did not like playing games. The resident preferred snacks and "people watching." Talking to other residents was considered his/her activities.

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5. Review of Resident #28's Preferences for Customary Routine and Activities, dated 7/5/23, showed:
-Do favorite activities-Very important;
-Go outside when good weather-Somewhat important.

Review of the resident's activity's progress note, dated 10/31/23 at 9:00 A.M., showed the resident joined the Halloween party yesterday and got punch to drink and collected candy from staff for trick or treating. Seemed to enjoy the party;
-No further activity's notes.

Review of the resident's quarterly MDS, dated 1/4/24, showed:
-Cognitively intact;
-No behaviors;
-Independent with mobility;
-Diagnoses included schizophrenia.

Review of the resident's care plan, updated 1/15/24, showed no information regarding activities.

During an interview on 3/28/24 at 11:53 A.M., the resident said the facility did not have many activities. All they had was bingo, and he/she was not interested in bingo. If the facility offered more activities, he/she would participate.

During an interview on 4/3/24 at 9:10 A.M., the AD said the resident did not enjoy activities and preferred to stay in his/her room. The resident participated in parties when they had them and liked snacks and beverages.

6. Review of Resident #33's activity notes,

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showed:
-On 6/13/23 at 3:14 P.M., spoke with resident in smoking area regarding upcoming birthday. Asked if he/she was excited and he/she responded yes. He/She was glad his/her birthday being soon was remembered;
-On 10/31/23 at 9:03 A.M., the resident joined the Halloween party yesterday and got to drink punch and collected candy from staff for trick or treating. Seemed to enjoy party;
-No further activity notes.

Review of the resident's Preference for Customary Routine and Activities, dated 11/27/23, showed:
-Do favorite activities-Very important;
-Go outside when good weather-Very important.

Review of the resident's quarterly MDS, dated 2/26/24, showed:
-Cognitively intact;
-No behaviors;
-Independent with mobility;
-Diagnoses included cancer and schizophrenia.

Review of the resident's care plan, revised 3/7/24, showed:
-Problem: The resident does go outside to smoke, interact with staff, attend activities that are passive, he/she enjoys popcorn, holiday celebrations and the monthly birthday parties;
-Goal: Resident will report participation in a satisfying activity program;
-Approach: Inform resident of upcoming activities by providing activity calendar, verbal reminders. Involve resident with those who have shared interests and praise involvement.

During an interview on 3/28/24 at 9:50 A.M., the

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F 679	Continued From page 6 resident said the facility did not offer any activities except for bingo. If they provided more activities, he/she would participate. During an interview on 4/3/24 at 9:10 A.M., the AD said the resident did not like activities. He/She preferred watching television and would participate in parties when they had them. 7. During an interview on 4/3/24 at 9:10 A.M., the AD said she was the only one doing activities for the entire facility. She does have a volunteer come in to play the violin and someone for Bible study. Her work hours are from 7:00 A.M. to 3:00 P.M., Monday through Friday. Most activities are "self-governed" and Resident #10 will call bingo and is her "biggest help." On weekends, she leaves board games and cards for the residents. Some residents receive one on one activities, but she does not have a list of residents who receive one on ones. She documents activity notes on her clipboard and on the activity calendar. During an interview on 4/3/24 at 12:57 P.M., the Administrator said the AD does not have much formal training. They had her set up to take a course, but wanted to see if she liked the position first. Resident Activities should be specific to resident preferences and should be documented in the progress notes. Activities should also be available on the weekends and the facility should provide the activities.	F 679		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an	F 680		

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activities professional who-
(i) Is licensed or registered, if applicable, by the State in which practicing; and
(ii) Is:
(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or
(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or
(C) Is a qualified occupational therapist or occupational therapy assistant; or
(D) Has completed a training course approved by the State.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the activity program was directed by a qualified professional. The census was 55.

Review of the facility's undated Job Description for Activity Director, showed:
-Qualifications;
-A minimum of a high school diploma;
-Completed a state approved activities director course;
-One year experience in a resident activities program in a health care setting;
-If an applicant has not met the last two of the above requirements, a consultant may be provided aimed at assisting the individual at achieving the requirements.

During an interview on 4/3/24 at 9:10 A.M., the Activity Director said she was the only one doing activities for the facility. She had not been trained on how to run an activity program. She was

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F 680	Continued From page 8 enrolled in the course, but had not started the program yet. She had been employed at the facility for about two years. She started out as the receptionist and transferred to the activity program about a year ago. During an interview on 4/3/24 at 10:11 A.M., the Administrator said the Activity Director did not have any formal training. She had the "book" and was enrolled in the class back in September 2023, but she did not start the classes because they wanted to see if she would remain consistent with the activity program. The activities program should be ran by a qualified professional.	F 680		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an environment free of accident hazards by not maintaining safe water temperatures in resident rooms on the North and South halls between 105 degrees Fahrenheit (F) and 120 F for 16 (Residents #49, #14, #12, #15, #54, #34, #8, #3, #27, #5, #43, #258, #18, #11, #52, and #40) of 31 sampled residents. The hot water temperatures in these resident room bathrooms ranged from 141 to 153 degrees F. The census was 55.	F 689		

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The administrator was notified on 3/28/24 at 7:00 P.M., of an immediate jeopardy (IJ), which began on 3/28/24. The IJ was removed on 3/29/24 as confirmed by surveyor verification.

Review of the facility's Safety of Water Temperatures Policy, dated December 2009, showed:
-Policy Statement: Tap water in the facility shall be kept within a temperature range to prevent scalding of residents;
-Policy Interpretation and Implementation;
-Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more that 105-120 degrees Fahrenheit, or the maximum allowable temperature per state regulation;
-Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log;
-Maintenance shall conduct periodic tap water temperature checks and record the water temperatures in a safety log;
-If at any time water temperatures feel excessive to the touch, staff will report this finding to the immediate supervisor;
-Direct-care staff shall be informed of risk factors for scalding/burns that are more common in the elderly, such as:
-decreased skin thickness;
-decreased skin sensitivity;
-peripheral neuropathy;
-reduced reaction time;
-decreased cognition;
-decreased mobility;
-decreased communication;

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-The length of exposure to warm or hot water, the amount of skin exposed, and the resident's current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolong exposure to warm or hot water will help to determine the safety of the situation.

1. Observation on 3/28/24 between 8:30 A.M., and 2:00 P.M., of the hot water heater in the mechanical room, behind the oxygen room, showed:
-Information on the water heater read, "Temperature setting:"
-Low = 100 degrees F;
-Triangle shape = 120 degrees F;
-A = 130 degrees F;
-B - 140 degrees F;
-C = 150 degrees F;
-D = 160 degrees F;
-Hot = 170 degrees F;
-Very hot = 180 degrees F;
-Time to produce 2nd and 3rd degree burns on adult skin;
-A = More than 30 seconds;
-B = Less than 5 seconds;
-C = 1 and 1/2 seconds;
-D = 1/2 second;
-Very Hot = Instantaneous.
-The temperature gauge set on very hot.

Observation on 3/28/24 between 10:30 A.M., and 2:00 P.M., of the hot water heater in the mechanical room, behind the linen room, showed the temperature gauge set between hot (170 degrees F) and very hot (180 degrees F).

During an interview on 3/28/24 at 2:00 P.M., the

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Maintenance Director said the residents had been complaining of the water being too cold and he would go in and turn the water heaters up a notch each time someone complained about the temperatures. The hot water heater behind the oxygen room served the south hall rooms and the hot water heater behind the linen room served the north hall rooms. These were the only water heaters in the west building.

During an interview on 3/28/24 at 2:20 P.M., the Corporate Regional Nurse acknowledged the gauge behind the oxygen room was set at very hot. It should not have been set that high.

During an interview on 3/28/24 at 2:25 P.M., the Administrator acknowledged the water heater behind the linen room was set between hot and very hot. The Maintenance Director should not be turning up the temperature on the water heaters without checking the actual temperature of the water in the rooms.

2. Review of Resident #49's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/19/24, showed:
-Moderately impaired cognition;
-Diagnoses included dementia and Alzheimer's disease;
-Walk 10 feet: Independent;
-Walk 50 feet with two turns: Independent;
-Walk 150 feet: Independent.

Review of Resident #14's quarterly MDS, dated 2/26/24, showed:
-Cognitively intact;
-Diagnoses included: Cerebral infarction (stroke) with residual deficits;

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-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Independent;
-Wheel 150 feet: Independent.

Observation of Resident #49 and Resident #14's shared bathroom on 3/28/24 at 10:50 A.M., showed the water temperature at the sink measured 142.7 degrees F, using a digital thermometer.

3. Review of Resident #12's quarterly MDS, dated 3/2/24, showed:
-Severe cognitive impairment;
-Diagnoses included dementia;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Dependent;
-Wheel 150 feet: Dependent.

Review of Resident #15's quarterly MDS, dated 2/5/24, showed:
-Moderately impaired cognition;
-Diagnoses included dementia;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Independent;
-Wheel 150 feet: Independent.

Observation of Resident #12 and Resident #15's shared bathroom on 3/28/24 at 11:01 A.M., showed the water temperature at the sink measured 144.6 degrees F, using a digital thermometer.

4. Review of Resident #54's admission MDS, dated 2/21/24, showed:
-Moderately impaired cognition;
-Diagnoses included seizures;
-Walk 10 feet: Supervision;

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-Walk 50 feet with two turns: Supervision;
-Walk 150 feet: Supervision.

Review of Resident #34's quarterly MDS, dated 3/3/24, showed:
-Cognitively intact;
-Diagnoses included vascular dementia;
-Walk 10 feet: Independent;
-Walk 50 feet with two turns: Independent;
-Walk 150 feet: Independent.

Observation and interview of Resident #54 and Resident #34's shared bathroom on 3/28/24 at 11:42 A.M., showed the water temperature at the sink measured 145 degrees F, using a digital thermometer. Resident #54 said sometimes the water is too hot.

5. Review of Resident #8's quarterly MDS, dated 1/13/24, showed:
-Cognitively intact;
-Diagnoses included stroke and overactive bladder;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: independent;
-Wheel 150 feet: independent.

Review of the resident #3's quarterly MDS, dated 1/22/24, showed:
-Cognitively intact;
-Diagnoses included: vascular dementia, bipolar and schizophrenia;
-Walk 10 feet: Independent;
-Walk 50 feet with two turns: Independent;
-Walk 150 feet: Independent.

Observation of Resident #8 and Resident #3's shared bathroom on 3/28/24 at 12:54 P.M.,

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showed the water temperature at the sink measured 145.2 degrees F, using a digital thermometer.

6. Review of Resident #27's quarterly MDS, dated 3/14/24, showed:
-Moderately cognitively impaired;
-Diagnoses included: Dementia, paranoid schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly) and major depressive disorder;
-Walk 10 feet: Independent;
-Walk 50 feet with two turns: Independent;
-Walk 150 feet: Independent.

Review of Resident #5's quarterly MDS, dated 1/17/24, showed:
-Diagnoses included bowel disease and schizophrenia;
-Walk 10 feet: Independent;
-Walk 50 feet with two turns: Independent;
-Walk 150 feet: Independent.

Observation of Resident #27 and Resident #5's shared bathroom on 3/28/24 at 1:00 P.M., showed the water temperature at the sink measured 147.2 degrees F, using a digital thermometer.

7. Review of Resident #43's quarterly MDS, dated 12/27/24, showed:
-Cognitively intact;
-Diagnoses included mild cognitive impairment;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Dependent;
-Wheel 150 feet: Dependent.

Review of Resident #258's quarterly MDS, dated

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3/14/24, showed:
-Moderate cognitively impaired;
-Diagnoses included: Dementia, paranoid schizophrenia and major depressive disorder;
-Walk 10 feet: Independent;
-Walk 50 feet with two turns: Independent;
-Walk 150 feet: Independent.

Observation of Resident #43 and Resident #258's shared bathroom on 3/28/24 at 1:03 P.M., showed the water temperature at the sink measured 141.2 degrees F, using a digital thermometer.

8. Review of Resident #18's annual MDS, dated 3/15/24, showed:
-Cognitively intact;
-Diagnoses included heart disease;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Independent;
-Wheel 150 feet: Independent.

Review of Resident #11's quarterly MDS, dated 3/4/24, showed;
-Cognitively impaired;
-Diagnoses included dementia and stoke;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Dependent;
-Wheel 150 feet: Dependent.

Observation on of Resident #18 and Residents #11's shared bathroom on 3/28/24 at 1:30 P.M., showed the water temperature at the sink measured at 152.4 degrees F, with a digital thermometer

9. Review of Resident #52's quarterly MDS, dated 1/23/24, showed:

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-Cognitively intact;
-Diagnoses included viral hepatitis and fractures;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Independent;
-Wheel 150 feet: Independent.

Review of Resident #40's quarterly MDS, dated 1/10/24, showed:
-Cognitively intact;
-Diagnoses included depression and neurogenic bladder;
-Used a wheelchair/scooter;
-Able to wheel 50 feet with two turns: Independent;
-Wheel 150 feet: Independent.

Observation of Resident #52 and Resident #40's shared bathroom on 3/28/24 at 1:30 P.M., showed the water temperature at the sink measured 153 degrees F, using a digital thermometer.

10. During an observation and interview on 3/28/24 at 2:00 P.M., Certified Nursing Aide (CNA) A said there were two residents who wandered and could wander into the bathroom and turn the water on. CNA A said the water temperature was not that hot. CNA A and the surveyor entered room 112 and checked the water. CNA A turned the water on and within a few seconds, said the water was hot. The water temperature was checked by the surveyor using a digital thermometer. The temperature read at 141 degrees F and was confirmed by CNA A. CNA A said they use the bathroom to provide care to residents, such as bed baths and incontinence care. CNA A said normally if the water was hot, he/she would mix in cold water. CNA A said

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he/she could not say if a confused resident would know to turn the cold water on to mix with the hot water.

During an interview on 3/28/24 at 2:00 P.M., the Maintenance Director said he did not know the water temperatures were so high in the resident rooms on the North and South halls. He took water temperatures monthly with a laser thermometer in resident rooms. He did not know laser thermometers could be unreliable for taking water temperatures. He did not have a different type of thermometer.

During an observation and interview on 3/28/24 at 2:05 P.M., the Director of Nursing (DON) said there are 13 residents who wander and could turn the water on in the bathroom, and two of the 13 residents go into the bathroom and play in the water. A water temperature above 110 would be considered hot. The residents have thinner skin and would be at risk for getting burnt. The DON and surveyor went to room 112 and the water temperature at the sink measured 139.5 (F).

During an interview on 3/28/24 at 2:20 P.M., the Corporate Regional Nurse said she knew the temperatures should not be over 120 degrees F. She did not know the Maintenance Director was using a laser thermometer. He should not have been using this type of thermometer to take water temperatures. She did not know the water temperatures were so high.

During interviews on 3/28/24 at 2:10 P.M. and 2:25 P.M., the Administrator said Maintenance staff was responsible for taking water temperatures monthly and keeping documentation of them. The water temperature

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F 689	Continued From page 18 should be between 105 and 120 degrees F. Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level "K." Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the "IJ" violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the deficiency was lowered to the "E" level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s).	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete pre (before) and post (after) dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys are not working properly) assessments and failed to have an accurate care plan for one of one resident reviewed for dialysis services (Resident #34). The census was 55. Review of the facility's Care of a Resident with	F 698		

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End-Stage Renal Disease (ESRD) Policy, date revised September 2010, showed:
-Residents with ESRD will be cared for according to currently recognized standards of care;
-Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents;
-Education and training of staff includes, specifically:
-The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis;
-Signs and symptoms of worsening condition and/or complications of ESRD;
-How to recognize and intervene in medical emergencies such as hemorrhages and septic infections;
-Timing and administration of medications, particularly those before and after dialysis.

Review of Resident #34's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/3/24, showed:
-Cognitively intact;
-Diagnoses included: ESRD;
-Received dialysis while a resident.

Review of the care plan in use at the time of survey, showed:
-Focus: I receive hemodialysis (HD, process for removal of waste and excess water from the blood due to kidney failure) at outside facility on Monday and Fridays. I had a right arm fistula (connection or passageway between an artery and a vein, surgically created for dialysis treatments) revision (using a piece of vein to patch or replace a narrow segment of the fistula)

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in 1/24. It is no longer in my wrist; it is mid arm. Edited 3/27/24;
-Interventions:
-Complete dialysis communication sheet on dialysis days;
-Monitor and report signs of localized infection right wrist (localized swelling, redness, pain or tenderness, heat at the infected area, purulent (pus) drainage, loss of function, turbid/bloody/malodorous dialysate (the material that passes through the membrane in dialysis);
-Monitor and report signs of systemic infection (fever, lassitude (fatigue) or malaise (lack of health often indicative of or accompanying the onset of an illness), change in mental status, anorexia, nausea, headache, lymph node tenderness/enlargement).
-The care plan did not show the current dialysis site location.

Review of the physician order sheet, in use at the time of survey, showed the following current orders:
-On Mondays and Fridays, document on dialysis communication sheet and send with the resident;
-A full set of vital signs (blood pressure (b/p), pulse (p), respirations (r) and temperature (T)) on Mondays and Fridays, must be charted or given to nurse no later than 9 A.M.;
-Upon return, complete open dialysis communication form, return to facility post-dialysis information, once a day on Monday and Friday.

Review of dialysis communication forms dated 2/5/24 through 4/1/24, showed:
-On 2/5/24, the dialysis center information and the return to facility post dialysis information was blank;

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-On 2/28/24, the dialysis center information and the return to facility post dialysis information was blank;
-On 3/1/24, the pre-dialysis information, dialysis center information, and the return to facility post dialysis information was blank;
-On 3/8/24, the return to facility post dialysis information was blank;
-On 3/11/24, the return to facility post dialysis information was blank;
-On 3/25/24, the dialysis center information, the b/p and p were blank and the return to facility post dialysis information was blank. General condition of resident: Dialysis center did not send back vital signs; Post facility return vital signs noted to be posted on the prior page (under dialysis center information).

Review of the progress notes, dated 2/1/24 through 4/1/24, showed:
-On 3/25/24 at 3:59 P.M., the resident returned from dialysis and refused his/her b/p to be taken;
-There was no documentation for 2/5, 2/28, 3/1, 3/8 or 3/11/24, showing the resident refused his/her assessment or the facility contacted the dialysis center to obtain their assessment.

Review of the vital signs tab, showed:
-On 2/5/24, only the post assessment b/p was documented;
-On 2/28/24, only the post assessment b/p was documented;
-On 3/1/24, pre-assessment: T and b/p was documented, post assessment only the b/p was documented;
-On 3/8/24, only the T was documented for pre and post assessment;
-On 3/11/24, no vital signs were documented;
-On 3/25/24, only the b/p was documented for pre

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and post assessment.

During an interview and observation on 4/2/24 at 9:30 A.M., the resident said his/her dialysis access site was on the right side of his/her upper chest, as he/she pulled his/her shirt up to show the catheter was on the right side of his/her upper chest. The resident said he/she went to an outside facility for dialysis on Mondays and Fridays.

During an interview on 4/2/24 at 12:30 P.M. Registered Nurse (RN) B said residents who receive dialysis services should have pre and post dialysis assessments completed. The assessment was documented on the dialysis communication form. The pre-assessment included checking the graft site (location where the resident received dialysis), bruit (a rumbling sound that you can hear) and thrill (a rumbling sensation that you can feel) and the resident's vital signs. The resident should take the dialysis communication form with them to dialysis and give the form back to the nurse when they return from dialysis. When the resident returns from dialysis, the nurse should complete the post dialysis assessment. The assessment included checking the graft site, bruit, and thrill, observe for any bleeding and obtain vital signs. Sometimes when the resident went out for dialysis, he/she would forget to take the communication form with him/her or forget to give the form to dialysis center, and sometimes the dialysis center did not send the form back. Sometimes when the resident returned to the facility, he/she would refuse to have his/her vital signs checked. If the resident refused the assessment, it should be documented on the dialysis communication form and in the medical

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record. If there was a blank on the dialysis communication form, that would mean the nurse did not do it.

During an interview on 4/2/24 at 12:45 P.M. and on 4/3/24 at 9:10 A.M., the Director of Nursing (DON) said residents who receive dialysis services should have a pre and post dialysis assessment completed by the nurse. The pre-dialysis assessment included what medications were given to the resident before going to dialysis and location of the shunt (surgically placed fistula) site and vital signs. The post dialysis assessment included vital signs, how many liters of fluid was taken off by dialysis, check for bruit and thrill, if any bleeding was observed and the general condition of the resident. The assessments were documented on the dialysis communication form. Sometimes when the resident returned from dialysis, he/she would refuse to have an assessment completed. If the resident refused, the DON expected for the nurse to reapproach the resident later. If there was a blank on the dialysis communication form, the DON could check the progress notes and check under the vital signs tab to check for the information. If the dialysis center did not return the form, the facility calls the dialysis center and requests the information and asks for the dialysis center to send the information over. Sometimes the dialysis center sends the information right over and sometimes they say they will send it and they don't. The DON checked the residents medical record and said:
-On 2/5/24, the dialysis center did not complete their portion of the form and no post assessment was completed and no post dialysis vitals were documented;
- On 2/28/24, the dialysis center did not complete

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F 698	Continued From page 24 their portion of the form and there was no post assessment completed; -On 3/1/24, the dialysis center did not complete their portion of the form and there was no post assessment completed. Only the post assessment b/p documented under vital signs; -On 3/8/24, the dialysis center did not send the form back. The post assessment was documented on the wrong page of the form. It was documented under the dialysis center portion of the form; -On 3/11/24, the nurse documented the post assessment under the dialysis center; -On 3/25/24, the nurse documented the post assessment under the dialysis center; -The DON would expect for the dialysis communication forms to be completed and she would expect for staff to follow the facility's policies and procedures. During an interview on 4/3/24 at 10:45 A.M., the Administrator said he would expect for staff to follow the facility's policies and procedures.	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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	F 812		

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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 ensure the ice machine in the main kitchen had an air gap between the drain pipe to prevent back siphonage. This had the potential to affect all residents who consumed drinks with ice. The census was 55.

Review of the facility Air Gap Policy for Ice Machine Draining Pipe, undated, showed:
-Objective: To ensure the sanitary operation of the ice machine by preventing the backflow of drain water into the ice machine through the establishment of an effective air gap;
-Policy Statement:
-All ice machines must have an air gap between the drain pipe of the ice machine and the floor drain or any other drainage system it connects to. This air gap is critical to prevent the possibility of contaminated water flowing back into the ice machine;
-Definition:
-An air gap is defined as a physical separation between the end of the drainage pipe and the overflow level of the receiving vessel (floor drain, sink, or other drainage systems). This gap must be open to the atmosphere to ensure no back siphonage occurs;
-Requirements:
-Air Gap Size: The air gap between the ice

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON GARDEN	4359 TAFT AVENUE SAINT LOUIS, MO 63116

(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	F 812		

machine's drain pipe and the receiving drainage system must be at least twice the diameter of the drain pipe but not less than 1 inch, ensuring compliance with most health and safety regulations;
-Location and Accessibility: The air gap must be located where it is easily visible for inspection and verification of the physical gap. It must not be obstructed by any equipment or materials that could compromise its effectiveness;
-Maintenance: Regular inspections must be conducted to ensure that the air gap remains unobstructed and functional. Any adjustments or repairs required to maintain the specified air gap must be performed promptly;
-Compliance: Failure to maintain the required air gap may result in the contamination of the ice machine and potential health risks to consumers. Such violations must be addressed immediately to ensure continued compliance with health and safety standards;
-Implementation:
-All staff responsible for the installation, maintenance, and inspection of ice machines must be trained on the importance of the air gap and how to verify its presence and adequacy.

Observations on 3/28/24 and 4/3/24 between 9:00 A.M. and 4:00 P.M., of the ice machine located in the main kitchen, showed a gray plastic tube extended from the back of the ice machine, into a white polyvinyl (PVC, a type of plastic used for pipes that carry water and for many other products) drain pipe. The area where the gray ice machine tubing was inserted into the PVC drain pipe was covered with dirt and debris. The PVC pipe was connected to the floor drain without an air gap observed.

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F 812	Continued From page 27 During an interview on 4/3/24 at 11:19 A.M., the Dietary Manager said he was aware ice machines should have an air gap. He was not aware the ice machine did not one. During an interview on 4/3/24 at 1:05 P.M., the Administrator said he expected an air gap to be present at the ice machine.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) 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 a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record

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review, the facility failed to follow acceptable standards of practice for infection control when staff failed to provide perineal care (peri care, cleansing the surface area between the thighs, extending from the pubic bone to the tail bone) per their policy for two residents (Resident #28 and #35) and when staff failed to perform hand hygiene and/or change both gloves during care for two residents. (Resident #258 and #46). The sample was 31. The census was 55.

Review of the facility's Perineal Care policy, undated, showed:
-Purpose: The purpose of this procedure is to provide cleanliness and comfort to the residents to prevent infections and skin irritation, and to observe the resident's skin condition;
-Steps in the procedure:
-For a female resident: wet the washcloth and apply soap or cleansing agent; wash perineal area, wiping from front to back. Separate labia and wash area downward from front to back, folding washcloth to clean area for each side of the labia. After task is completed, place soiled wash cloth and clothes in empty trash bag. Sanitize hands, then apply new gloves. Continue to wash the perineum moving inside outward to include thighs, alternating from side to side, using downward stokes. Rinse perineum thoroughly in the same direction, using fresh water and clean wash cloth. Turn resident on the side. Rinse wash cloth and apply soap or skin cleansing agent. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks, folding wash cloth to clean rectal area. Rinse thoroughly using the same technique and dry area thoroughly. Remove gloves and sanitize hands.

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Review of the facility's wound care policy, date revised October 2010, showed:
-Steps in procedure:
-Use disposable cloth to establish clean field on resident's overbed table. Place all items to be used during procedure on clean field. Arrange supplies so they can be easily reached.
-Wash and dry hands thoroughly;
-Put on exam gloves. Loosen tape and remove dressing;
-Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly;
-Put on gloves;
-Dress the wound.

Review of the facility's Handwashing/Hand Hygiene policy, date revised August 2019, showed:
-Policy statement: This facility considers hand hygiene the primary means to prevent the spread of infections;
- All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections;
-All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors;
-Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:
-Before and after direct contact with residents;
-Before handling clean or soiled dressings, gauze pads, etc.;
-Before moving from a contaminated body site to a clean body site during resident care;

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-After handling used dressings, contaminated equipment, etc.;
-After removing gloves;
-The use of gloves does not replace hand washing/hand hygiene.

1.. Review of Resident #28's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 1/4/24, showed:
-Cognitively intact;
-Occasionally incontinent of bowel and bladder;
-Toilet hygiene: partial/moderate assistance, helper does less than half the effort;
-Diagnoses included: high blood pressure and bowel disease.

Review of the care plan in use at the time of survey, showed:
-Focus: Resident had occasional urinary incontinence and was frequently incontinent of bowel;
-Interventions: Provide incontinence care after each incontinent episode.

Observation on 4/1/24 at 9:23 A.M., showed the resident walked into the bathroom and used the bathroom. The resident stood up. Certified Medication Technician (CMT) E performed hand hygiene and put gloves on. CMT E used a wipe to wipe the resident from front to back, three times using the same wipe and without turning the wipe. Then, CMT E used a new wipe and wiped the resident, from the buttocks down towards the peri area. CMT E obtained a new wipe and wiped the resident from the peri area up to the buttocks.

During an interview on 4/2/24 at 9:05 A.M., CMT E said the resident preferred to stand up during

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perineal or personal care. When providing perineal care to the resident on 4/1/24, he/she wiped the resident's anal area improperly by wiping from top to bottom while the resident was in standing position. He/She did not provide the resident's personal care regularly due to his/her primary task was to administer medications. During perineal care, he/she used one wipe for each side of the groin, each labia fold, anal area, and each side of buttocks. Gloves should be changed before and after providing care and if soiled. When gloves are changed, both gloves should be changed.

2. Review of Resident #35's quarterly MDS, dated 12/31/23, showed:
-Should a brief interview for mental status be conducted? No;
-Made decisions regarding tasks of daily life: Severely impaired, never/rarely made decisions;
-Always incontinent of urine and bowel;
-Toilet hygiene: dependent-helper does all the effort. Resident does none of the effort to complete the activity;
-Upper extremity: impairment on one side;
-Diagnoses included: Stroke, hemiplegia (paralysis of one side of the body) or hemiparesis (muscle weakness or partial paralysis on one side of the body)

Review of the care plan in use at the time of survey, showed:
-Focus: Resident had urinary and bowel incontinence. Resident was unable to conceptualize the need to use the bathroom related to having a stroke with residual effects;
-Interventions: Provide incontinence care after each incontinent episode.

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Observation on 4/1/24 at 7:40 A.M., showed the resident lay in bed. Certified Nurse Aide (CNA) D, performed hand hygiene, put gloves on, pulled the resident's brief down, and provided peri care, wiping from front to back without separating the labia. CNA D removed his/her gloves, performed hand hygiene, put gloves on and completed the rest of the resident's care.

During an interview on 4/2/24 at 10:29 A.M., CMT F said he/she would provide the residents' perineal care while in bed. He/She would wipe the resident's perineal area from front to back. Hand hygiene was done before and after glove changes. Gloves are changed when you go from dirty to clean.

3. During an interview on 4/2/24 at 11:15 A.M., CNA H said when peri care was performed, hand hygiene should be done prior to the start of care. He/She would cleanse the skin folds and change his/her gloves, then wipe the peri area from the front to back, using a clean wipe for each swipe. For female residents, he/she would separate the labia and wipe from front to back. Then, he/she would wash the resident's back side.

During an interview on 4/2/24 at 12:45 P.M., the Director of Nursing (DON) said staff should perform hand hygiene before and after care and if their hands become soiled. When staff perform peri care they should wipe from front to back, using one wipe for each swipe. Staff should separate the labia when providing care.

4. Review of Resident #258's annual MDS dated 1/23/24, showed:
-Moderately impaired cognition;
-Diagnoses included: dementia, anxiety, and

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schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly);
-Had surgical wound;
-Received surgical wound care.

Review of the physician order sheet, in use at the time of survey, showed:
-An order for: Clean area to right scapular (shoulder) area with wound cleanser, pat dry, apply abdomen (ABD) pad (highly absorbent dressing) and secure with hypafix (dressing) daily and as needed until healed, once a day;
-An order for: cleanse surgical wound to right abdomen with normal saline (NS, mixture of sodium chloride and water), apply ABD pad to wound every day and as needed.

Review of the care plan, in use at the time of survey, showed:
-Focus: Resident had a surgical wound to his/her right upper extremity (RUE). 3/22/24, returned from hospital with antibiotic (ABT) for abscess (enclosed area of pus) right upper back;
-Intervention: Dressing changes as ordered.

Observation on 4/1/24 at 2:10 P.M., showed Registered Nurse (RN) B, performed hand hygiene and put gloves on and removed the dressing on the right side of the resident's abdomen. RN B removed one glove and applied a new glove, no hand hygiene was done prior to applying a new glove. Then he/she cleaned the wound and removed one glove and put a new glove on, without completing hand hygiene prior to applying a new glove. RN B applied the new dressing. RN B removed both gloves and performed hand hygiene and applied new gloves. He/She removed the dressing from the right scapula area. RN B removed one glove and put a

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new glove on. RN B did not complete hand hygiene prior to applying the new glove and then cleaned the wound with wound cleanser. Then, he/she changed both gloves. CNA C entered the room and performed hand hygiene and put on gloves and held the ABD pad into place while RN B taped the dressing into place.

5. Review of Resident #46's significant change MDS, dated 1/4/24, showed;
-Moderately impaired cognition;
-Diagnoses included: Parkinson's disease (central nervous system disorder that affects movement), arthritis, high blood pressure and heart failure;
-Application of dressing to feet.

Observation and interview on 4/1/24 at 1:49 P.M., showed RN B said the resident had an ingrown toe nail, as he/she prepared treatment supplies for the resident. With clean gloves on both hands, RN B assisted another resident, who wandered in the resident's room, out of the room. RN B held the other resident's hand with his/her gloved left hand, while holding the treatment supplies (wound cleanser bottle, dressings, and tape) with his/her right hand against his/her chest. RN B returned to the treatment cart, placed the supplies on top of the cart and changed only his/her left glove using the gloved right hand. He/She then entered the resident's room to provide treatment to his/her left foot. He/She removed the resident's pressure relief boot to right foot and assessed and touched the heel with scabbed wounds. He/She then obtained and wet a dressing and cleansed the left great toe and applied dry dressing. RN B did not change gloves and/or perform hand hygiene during the procedure.

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F 880	Continued From page 36 6. During an interview on 4/2/24 at 11:15 A.M., CNA H said when gloves are changed, both gloves should be changed. During an interview on 4/2/24 at 11:20 A.M., RN B said, hand hygiene should be performed before and after providing care for the residents or if soiled. Staff should change both gloves when they change their gloves. During an interview on 4/2/24 at 12:45 P.M., the DON said staff should change both gloves when they change their gloves. By not changing both gloves, there was a possible risk for cross contamination or infection. The DON expected staff to follow the facility's policies and procedures. During an interview on 4/3/24 at 10:45 A.M., the Administrator said he expected staff to follow the facility's policies and procedures.	F 880		

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A3023	19 CSR 30-85.032(24) Hot Water 105-120 Degrees F The facility shall ensure that plumbing fixtures that supply hot water and are accessible to the residents, shall be thermostatically controlled so the water temperature at the fixture does not exceed one hundred twenty degrees Fahrenheit (120°F) (49°C). The water shall be at a temperature range of one hundred five degrees Fahrenheit to one hundred twenty degrees Fahrenheit (105°F-120°F) (41°C-49°C). I/II This regulation is not met as evidenced by: Class I* See the deficiency cited at F689. *The higher classification merited due to the extent of the violation. Note: At the time of the survey, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the on-site visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level.	A3023		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable	A4075		

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A4075	Continued From page 1 nursing practice. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F698.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II See the deficiency cited at F880.	A4086		
A4101	19 CSR 30-85.042(92) Activity Program The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities, and activities outside the facility as appropriate to	A4101		

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A4101	Continued From page 2 his/her needs and interests. II/III This regulation is not met as evidenced by: Class II* See the deficiencies cited at F679 and F680. *The higher classification merited due to the extent of the violation and the effect of the violation on the residents.	A4101		
A7042	19 CSR 30-87.030(40) Ice Store/Dispense, No Contamination, Air Gap Ice shall be dispensed only with scoops, tongs or other ice-dispensing utensils or through automatic self-service, ice-dispensing equipment. Ice-dispensing utensils shall be stored on a clean surface or in the ice with the dispensing utensil ' s handle extended out of the ice. Between uses, ice transfer receptacles shall be stored in a way that protects them from contamination. Ice storage bins shall be drained through an air gap. III This regulation is not met as evidenced by: See the deficiency cited at F812.	A7042		

PLAN OF CORRECTION

Provider/Supplier Name:	Avalon Garden Nursing and Rehabilitation Center
Street Address, City, Zip:	4359 Taft Avenue. Saint Louis, MO 63116
Date of Survey:	04/03/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265828

ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
F679	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and federal law. <u>F679</u> The facility must provide, based on the comprehensive assessment and care plan and preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. 1.The following residents were affected... Resident #27. Resident #5. Resident #28. Resident #33.	05/07/2024

	Corrective Action: Activity Director is beginning and maintaining a daily activity log to properly document/track resident activity participation. Activity Director begins coursework on May 7th, 2024 in an Activity Director workshop to be better educated on maintaining an organized activity program with a variety of activities. Activity Director has added different games/outdoor events to activity calendar to better suit a diverse background of resident wishes. The Activity Director will maintain a running documented list of all residents who receive one on ones and ensure adequate stimulation of each resident. The Activity Director will audit and document progress notes and care plans monthly and update each according to activity observations and assessments. Identification of Others: All residents have a potential to be affected. Quality Improvement Plan/Review All monthly activity audits and progress notes will be submitted to the quarterly meeting of the QAPI Committee for review and further recommendations if indicated.	
F680	F680 The Activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed… Corrective Action:	05/07/2024

	The Activity Director will be starting, and is enrolled in, a State approved accredited course on May, 7th 2024. The Activity Director will learn the importance on maintaining a robust and organized Activity Program for each resident. Identification of Others: All residents have a potential to be affected. Quality Improvement Plan/Review Upon completion of course, the certificate will be submitted to the quarterly meeting of the QAPI Committee for review and further recommendations if indicated.	
F689	F689 The facility must ensure the resident environment remains free of accident hazards. Maintaining safe water temperatures. 1.The following residents were affected... Resident #49 Resident #14 Resident #12 Resident #15 Resident #54 Resident #34 Resident #8 Resident #3 Resident #27 Resident #5 Resident #43 Resident #258 Resident #18 Resident #11 Resident #52 Resident #40 Corrective Action:	05/07/2024

	Administrator will ensure all water tanks and temperatures are logged and audited three times a week for one month to ensure all water temperatures remain in safety range, 105–120-degree F. And thereafter as needed. The Maintenance Director will continue logging water temps monthly and documenting temps to ensure compliance and temperatures remain in safety ranges. The Administrator and/or designee will audit 5, different, random resident rooms weekly for six weeks, and as needed, then designee will monitor monthly routinely thereafter to ensure proper temperature ranges met. New Maintenance Director will be trained that Hot Water tanks are only to be adjusted with the authorization of the Administrator as safety zones need not be changed. <u>Identification of Others:</u> All residents have a potential to be affected. <u>Quality Improvement Plan/Review</u> All audits pertaining to water temperatures will be submitted to the quarterly meeting of the QAPI Committee for review and further recommendations if indicated.	
F698	<u>F698</u> The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 1.The following residents were affected...	05/07/2024

	Resident #34 Corrective Action: The DON and/or designee will in-service all essential nursing staff on proper pre and post assessment procedures on dialysis patients as to ensure doctors' orders are followed explicitly. The DON and/or designee will audit dialysis observations twice a week to ensure completion for six weeks and thereafter as needed. The DON has added a separate order to be signed off on for vital signs when it comes to dialysis patients, adding an additional layer of support and completion. Identification of Others: All residents have a potential to be affected. Quality Improvement Plan/Review All audits pertaining dialysis post and pre assessments, as well as vital sign audits will be submitted to the quarterly meeting of the QAPI Committee for review and further recommendations if indicated.	
F812	F812 The facility must procure food from sources approved or considered satisfactory by federal, state, or local authorities. Ice machines drain not in compliance per facility "airgap" policy.	05/07/2024

	Corrective Action: Maintenance Director had Ice Machine drain hose was removed from inside of the PVC drainpipe to avoid back siphonage of potential contaminants, immediately. Administrator and Maintenance Director added a funnel and air gap to ice machine drain to ensure separation and air gap to prevent back siphonage and contamination from drain. The drainage hose was also elevated out of drain tube and affixed to the funnel. The Administrator and/or designee will visually inspect ice machine drain monthly to ensure funnel and airgap is still secure and in place to avoid back siphonage and contamination per "airgap" facility policy. Identification of Others: All residents have a potential to be affected. Quality Improvement Plan/Review Ice Machine airgap policy will be submitted to the quarterly meeting of the QAPI Committee for review and further recommendations if indicated.	
F880	F880 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent communicable diseases and infections. 1.The following residents were affected... Resident #28-peri care Resident #35-peri care Resident #258-hand hygiene Resident #46-hand hygiene	05/07/2024

	Corrective Action: The DON and/or designee will in-service all essential nursing staff on proper hand washing/hygiene. The DON and/or designee will require skill checkoffs to ensure proper technique and form is adhered to for proper hand washing/hygiene. The DON and/or designee will in-service all essential nursing staff on proper perineal care. The DON and/or designee will require skill checkoffs to ensure proper technique and form is adhered to for proper perineal care. Identification of Others: All residents have a potential to be affected. Quality Improvement Plan/Review All audits/in-services pertaining to Perineal Care and Hand Hygiene will be submitted to the quarterly meeting of the QAPI Committee for review and further recommendations if indicated.	
	E000 This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and federal law.	05/07/2024

A3023	Please refer to poc F689	05/07/2024
A4075	Please refer to poc F698	05/07/2024
A4086	Please refer to poc F880	05/07/2024
A4101	Please refer to poc F679 and F680	05/07/2024
A7042	Please refer to poc F812	05/07/2024

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.