

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026
NAME OF PROVIDER OR SUPPLIER Delhaven Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 5460 Delmar Blvd Saint Louis, MO 63112	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents requiring dialysis received services consistent with professional standards of practice when staff failed to conduct an ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments for two residents (Residents #1 and #3). The facility identified two residents receiving dialysis and problems were found with both. The sample was 3. The census was 35. 1. Review of Resident #1's medical record, showed:-admission date 2/5/26;-Diagnoses included end stage renal disease (ESRD, permanent kidney failure that requires a regular course of dialysis or a kidney transplant). Review of the resident nurse's note, dated 2/5/2026 at 1:42 P.M., showed the resident arrived via transportation from the dialysis center. They were unable to dialyze him/her due to inability to lift the resident. The resident requires Hoyer pad, not sent with him/her from the previous facility. The resident is an assist times two with a Hoyer lift. He/She refused to allow the nurse to assess skin wounds that are noted on his/her lower extremity. The dialysis shunt (surgically created connection between artery and vein that acts as an access point for dialysis) is in the resident's right upper extremity with thrill and bruit noted. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/26, showed the resident cognitively intact. Review of the resident's care plan, in use at the time of survey, showed the following:-Focus: The resident is at risk for ineffective tissue perfusion (process in which blood carries oxygen and nutrients to body tissues and organs) and excessive fluid volume related to a diagnoses of ESRD. The resident is dependent on dialysis;-Tasks: Ensure to attend dialysis appointments as scheduled. Monitor the resident's fistula (surgically created connection between the artery and a vein), monitor the bruit (whooshing sound heard with a stethoscope over a functioning fistula) and thrill (vibration felt when touching a fistula) as ordered. Review of the resident's active physician order summary (POS), showed no physician orders for the resident to receive dialysis, and no physician orders for staff to monitor the resident's dialysis site or to check the resident's bruit or thrill before and after dialysis. Observation on 3/16/26 at 10:35 A.M., showed the resident had a dialysis shunt to his/her right upper arm. During an interview, the resident said he/she goes to dialysis three times a week, on Tuesdays, Thursdays, and Saturdays. The staff at the facility do not check his/her dialysis shunt before or after dialysis treatment. 2. Review of Resident #3's medical record, showed the following:-admission date 3/4/26;-Diagnoses included ESRD. Review of the resident's care plan, in use at the time of survey, showed the following:-Focus: Resident at risk for imbalanced fluids and ineffective tissue perfusion related to diagnoses of ESRD;-Tasks: Ensure the resident attends dialysis at scheduled times and nursing to assess the resident as ordered. Review of the resident's active POS, showed:-An order, dated 3/5/26, for dialysis on Tuesdays, Thursdays, and Saturdays, with chair time at 10:45 A.M.;-No physician orders for staff to monitor the resident's dialysis access site or to check his/her bruit and thrill. Observation on 3/16/26 at 11:45 A.M., showed the resident with a dialysis shunt in his/her upper left arm. During an interview, the resident said he/she goes to dialysis on Tuesdays, Thursdays, and Saturdays. The staff do not always check his/her vital signs or check his/her bruit and thrill before or after dialysis. 3. During an interview on 3/16/26 at 11:37 A.M., Licensed Practical Nurse (LPN) A said before a (continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident goes to dialysis, the nurse should get a set of vital signs, make sure the resident is administered his/her medications, and check the resident's bruit and thrill, then document it in the resident's medical record. The resident should have a physician order for dialysis and an order for staff to monitor the resident's bruit and thrill. The resident's bruit and thrill should be monitored to ensure they are functioning properly. He/She was not aware the residents did not have proper physician orders for dialysis. 4. During an interview on 3/16/26 at 12:55 P.M, with the Director of Nursing (DON) and Administrator, the DON said the facility did not have a dialysis policy. The Assistant Director of Nursing (ADON) is responsible for ensuring the residents have orders for dialysis and orders for staff to monitor the resident's bruit and thrill. The DON was not aware the residents did not have physician orders for dialysis or orders to monitor the bruit and thrill and she did not have an explanation as to why the residents did not have the proper orders. It is important to have physician orders for dialysis for staff to monitor the resident for any infection. The Administrator agreed with the DON and did not know why the facility did not have a policy related to dialysis. 2742660</p>		