

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2025
NAME OF PROVIDER OR SUPPLIER  Estates of St Louis, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 2115 Kappel Drive Saint Louis, MO 63136	
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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on record review and interview, the facility failed to ensure resident funds were placed in an account separate from the facility operating account. The facility did not provide residents with refunds of their personal funds from the operating account in a timely manner for nine residents (Resident #7, #8, #9, #12, #13, #14, #15, #16 and #17). Facility staff failed to provide the Social Security and/or Medicaid monthly allowance in a timely manner, which did not allow the resident/financial guardian the right to manage his/her financial affairs for three residents (Resident #3, #7 and #8) out of a sample of seven. The facility census was 79.1. Record review of the facility-maintained Accounts Receivable Aging Report, dated 12/16/25, showed the following residents with personal funds held in the facility operating account. Resident - Amount Held in Operating Account#7 - \$724.75#8 - \$1,533.00#9 - \$2,096.00#12 - \$636.00#13 - \$1,327.00#14 - \$4,241.67#15 - \$1,325.85#16 - \$3,310.00#17 - \$3,871.10Total - \$19,065.37 Record review of the facility-maintained paperwork showed the facility did not credit the resident funds held in the operating account until 12/18/25, two days after the department entered the facility for a complaint investigation. During email correspondence dated 12/18/25 at 2:52 P.M., the Accounts Receivable Manager said the credit balances were created due to:- Resident #9 received a backpay in 08/2024;- Resident #7, #8, #12 and #17 received a backpay in 05/2025;- Resident #13 received a backpay in 08/2025;- Resident #16 received a backpay in 07/2025;-Resident #14's guardian paid his/her bill monthly even though there was a credit on the account;- Resident #15 had a surplus adjustment in 05/2025. During email correspondence dated 12/18/25 at 4:29 P.M., the Accounts Receivable Manager said the credits were not done timely. 2. Record review of the facility-maintained Resident Trust Transaction History for the period 01/01/25 through 12/16/25, showed the following residents did not receive the \$50 Social Security/Medicaid monthly allowance timely for the following months: Resident - Amount - Month#3 - \$0 - 03/2025 \$0 - 04/2025 #7 - \$0 - 03/2025 \$0 - 04/2025 #8 - \$0 - 03/2025 \$0 - 04/2025 Record review of the updated facility-maintained Resident Trust Transaction History for the period 01/01/25 through 12/18/25, showed Residents #3, #7 and #8 were not refunded the \$50 monthly allowance for 03/2025 and 04/2025 until 12/17/25 and 12/18/25. During email correspondence dated 12/18/25 at 8:38 A.M., the Accounts Receivable Manager said he/she was not sure why there were no deposits and/or Social Security for 03/2025 and 04/2025 for Residents #3, #7 and #8. Complaint MO2689890 *The higher classification merited due to the impact when combined with other deficiencies</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265712
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