STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265717	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Health Care Center	3645 Cook Ave Saint Louis, MO 63113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a representative of the State Long-Term Care (LTC) Ombudsman of transfer and discharge and failed to provide a written notice of transfer/discharge for one resident (Resident #4) when the resident was transferred to another facility. The sample was four. The census was 114. Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, dated 5/14/24, showed the following: -Purpose: -Establish policy and procedure regarding the transfer/discharge of residents; -Definitions: -Facility-initiated transfer or discharge: A transfer or discharge which the resident objects to, which did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences; a. Consent to or Agreement with the discharge or transfer means that the resident or their legally authorized representative has consented to or agreed with the transfer or discharge; b. Consent or agreement of the resident means that resident, with sufficient mental capacity to fully understand the effects and consequences of the transfer or discharge, consents to or agrees with the transfer or discharge; c. Legally authorized representative means a duly appointed guardian or attorney-in-fact who has current and valid power to make health care decisions or the resident; d. Any consent shall be documented in the medical record. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Transfer and discharge: Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. Refusal to admit a former resident shall not constitute a discharge if the former resident has been absent from the facility for more than ninety days. -Notice of Discharge or Transfer: A. Who Must Receive Notice; Before any resident is transferred or discharged under a Facility-Initiated Transfer or Discharge, the Facility must: 1. Notify the resident and the resident representative the reason for the transfer or discharge in writing in a manner they understand; 2. Notify a representative of the Office of the State Long-Term Care Ombudsman. a. A copy of the discharge/transfer notice shall be sent to the Ombudsman at least 30 days in advance of the discharge or as soon as possible; b. In the case of an emergency or immediate discharge, copies shall be sent to Ombudsman. This notice shall be sent when practicable and a monthly list is acceptable and should include if the resident's return is expected. B. What Notice Must Include: The written notice shall include the following information: 1. Reason for the transfer or discharge; 2. Effective date of the transfer or discharge; 3. Location to which the resident is being transferred or discharged , including specific address; 4. Resident's right to appeal the transfer or discharge notice to the state agency within 30 days of the receipt of the notice; 5. That if the resident files an appeal, they can remain in the facility unless and until a hearing official finds otherwise. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/17/25, showed the following: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-admitted [DATE]; -Short and long term memory ok; -No moods or behaviors; -No impairment to extremities; -Partial/Moderate assistance with activities of daily living; -Diagnoses of high blood pressure, diabetes, stroke and seizure disorder. Review of the resident's facesheet, showed he/she was his/her own responsible party. Review of the resident's Social Service note, dated 3/25/25 at 4:11 P.M., showed the Social Service Director (SSD) spoke with resident's family member concerning his/her transfer to another facility; he/she had no objections and will follow-up once the transfer is complete. Review of the resident's nurse's note, dated 3/26/25 at 7:39 P.M., showed the resident discharged to another facility by taxi cab, accompanied by facility staff. The resident expressed disappointment with having to move to another facility. The resident medications was sent by administrator for safety. The resident's remainder of belongings will be sent to new facility in the morning. Review of the resident's medical record, showed no documentation of transfer/discharge notice. During an interview on 4/10/25 at 2:19 P.M., the SSD said the transfer was initiated by the Corporate staff. The SSD said he/she spoke with the resident's family member but did not speak with the resident about the discharge/transfer. During an interview on 4/11/25 at 8:13 A.M., the Administrator said the resident has been at the facility about three years. The resident was incarcerated for being a sex offender. He/She had gotten out then had a stroke and came to the facility. The Administrator said when the resident came to the facility, she did not know the facility could not have sex offenders as residents. The Director of Operations (DOO) contacted her, could not remember when, and asked if the facility had any sex offenders. The Administrator said they had one, Resident #4. The DOO said they could not have a sex offender in the building due to the locations of schools and churches in the area. The Administrator was told she had to discharge the resident to another facility. The Administrator said she did not speak with the resident, did not issue a discharge notice to the resident and did not contact the Office of the State LTC Ombudsman. The Administrator said she was not aware of the facility discharge policy from memory. She just swapped the resident for another resident from the other facility. The Administrator said the resident did not exhibit any behaviors. During an interview on 4/11/25 at 9:26 A.M., the DOO said there was a concern with a sex offender at another one of his/her facilities. When he/she did an audit and put in the facility's address, a sex offender was located at the facility, Resident #4. The facility could not have a sex offender, so the resident had to be moved to another facility. The DOO said he/she expected the Administrator to follow the facility's policy on discharge/transfer and to follow the proper protocol.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards when staff failed to administer and document medications as order by the physician for three residents. (Resident #10, Resident #12 and Resident #15). The sample was 13. The census was 111. Review of the facility's Transcription of Orders/Following Physician's Order Policy, dated 5/18/24, showed the following: -Purpose: The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders. -Procedure: A. Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in orders section; B. The Licensed/Registered Nurse will check the emergency kit to verify if the medication is present in the facility to begin immediately. If the medication is not available, the facility may contact the backup pharmacy to deliver the medication sooner. If the medication is unable to be started within 24 hours of the order, the prescribing physician will be notified, and further orders will be obtained. If a stat medication is ordered, the physician will be made aware of facility availability in the case that an alternative is needed. Review of the facility's Medication Administration Policy, dated 6/26/24, showed the following: -Purpose: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. It is the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines; -Policy: General Medication Administration Process: -Sign Medication Administration Record (MAR) after administered. For those medications requiring vital signs, record the vital signs onto the MAR; -If medication is a controlled substance, sign narcotic book; -Report and document any adverse side effects or refusals; -Correct any discrepancies and report to nurse manager. 1. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/3/25, showed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No cognitive impairment; -No moods or behaviors; -No impairment to extremities; -Mobility device of walker and wheelchair; -Supervision with activities of daily living (ADLs) -Diagnoses of orthopedic condition and depression. Review of the resident's care plan, dated 5/21/25, showed the following: -Problem: The resident has a potential for behavior problem; -Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of the resident's Order Summary Report, dated 6/3/25, showed the following: -3/10/25, Duloxetine HCl Oral Capsule Delayed Release Particles (used to treat depression and anxiety) 40 milligrams (mg), give two capsules by mouth one time a day related to pain; -3/10/25, Famotidine Oral Tablet (to treat stomach ulcers) 20 mg, give 20 mg by mouth one time a day for heartburn; -3/10/25, Hydroxychloroquine Sulfate Oral Tablet (to treat inflammatory conditions, including rheumatoid arthritis) 400 mg, give one tablet by mouth in the morning related to bilateral post traumatic osteoarthritis of the hip. Review of the resident's May 2025 MAR, showed the following: -Duloxetine HCl Oral Capsule: left blank on 5/13, 5/18, 5/31/25; -Famotidine Oral Tablet: left blank on 5/12, 5/16-19, 5/21, 5/25-26/25; -Hydroxychloroquine Sulfate Oral Tablet: -Staff documented 9=See Progress Notes: 5/1-2, 5/5-7, 5/9, 5/12, 5/15, 5/16, 5/19, 5/20, 5/24, 5/26, 5/28-30/25; -Left blank on: 5/13, 5/18 and 5/31/25; -Review of the resident's progress notes, showed no documentation regarding the medication. During an interview on 6/3/25 at 10:25 A.M., the resident said he/she had a problem getting all his/her medications. He/She had been told the facility did not have his/her pain medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #12's quarterly MDS, dated [DATE], showed the following: -No cognitive impairment; -No behaviors; -Supervision with ADLs; -Diagnoses of high blood pressure, End Stage Renal Disease (ESRD) (the final, irreversible stage of chronic kidney disease, where the kidneys can no longer function adequately to sustain life without dialysis or kidney transplantation), anxiety and depression. Review of the resident's care plan, dated 4/8/25, showed the following: -Problem: The resident has a potential for a behavior problem regards to anxiety and depressive disorder; -Intervention: Administer medications as ordered. Monitor/document for side effects and effectiveness. Review of the resident's Order Summary Report, dated 6/3/25, showed the following: -5/20/24, Nortriptyline (used to treat depression) HCl Oral Capsule 25 mg, give one capsule by mouth at bedtime related depression; -5/20/24, Melatonin Oral Tablet 3 mg, give two tablet by mouth at bedtime related to insomnia; -5/20/24, Amlodipine Besylate Oral Tablet 10 mg, give one tablet by mouth one time a day related to stroke. Review of the resident's May 2025 MAR, showed the following: -Nortriptyline HCl Oral Capsule: Left blank on 5/5, 5/13-22, 5/24-26 and 5/31/25; -Melatonin Oral Tablet: Left blank on 5/5, 5/13-22, 5/24-26 and 5/31/25; -Amlodipine Besylate Oral Tablet: Left blank on 5/13 and 5/19-23/25. During an interview on 6/3/25 at 9:45 A.M., the resident said he/she did not get his/her Nortriptyline medication at night. He/She said there were some other medication he/she did not get, but he/she was not sure of the names of the medications. 3. Review of Resident #15's Facesheet, showed the following: -Date of admission: [DATE]; -Diagnoses of heat failure and acute kidney failure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan dated 6/17/25, showed the following: -Problem: The resident has altered cardiovascular status; -Intervention: Assess for chest pain every (specify). Enforce the need to call for assistance if pain starts. Review of the resident's Order Summary Report, dated 6/17/25, showed the following: -7/12/24, Hydralazine HCl Oral Tablet (used to treat high blood pressure) 25 mg, give one tablet by mouth three times a day for hypertension; -This order was discontinued on 6/6/25. -6/6/25, Hydralazine HCl Oral Tablet 25 mg, give three tablets by mouth three times a day for hypertension; -7/12/24, Isosorbide Dinitrate Oral Tablet (used to prevent angina (chest pain) caused by coronary artery disease) 20 mg ,give one tablet by mouth three times a day for hypertension; -This order was discontinued on 6/6/25; -6/6/25, Isosorbide Dinitrate Oral Tablet 20 mg ,give one and one half tablets by mouth three times a day for hypertension. Review of the resident's June MAR, showed the following: -7/12/24, Hydralazine HCl Oral Tablet 25 mg, one tablet three times a day: -7:00 A.M.: Left blank on 6/1-4/25, 9=See progress notes: 6/5/25; -12:00 P.M.: Left blank on 6/1-4/25, 9=6/5/25; -8:00 P.M.: Left blank on 6/1-3/25; -6/6/25, Hydralazine HCl Oral Tablet 25 mg, three tablets three times a day: -12:00 P.M.: 9=6/6, Left blank: 6/14; -8:00 P.M.: 9=6/6, Left blank: 6/16. Review of the resident's progress notes showed no documentation regarding the medication. -7/12/24, Isosorbide Dinitrate Oral Tablet 20 mg ,give one tablet by mouth three times a day: -7:00 A.M., Left blank on 6/1-4/25, 9=6/5/25; -12:00 P.M., Left blank on 6/1-4/25, 9=6/5/25; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8:00 P.M., Left blank on 6/1-3/25; -6/6/25, Isosorbide Dinitrate Oral Tablet 20 mg ,give one and one half tablets by mouth three times a day: -12:00 P.M., 9=6/6, 6/14, left blank; -8:00 P.M., 9=6/6, 6/16, left blank; -Review of the resident's progress notes showed no documentation regarding the medication. During an interview on 6/16/25 at 10:42 A.M., the resident said he/she did not get his/her blood pressure medication all the time. The resident said there had been times when the medications had been missed. 3. During an interview on 6/6/25 at 1:05 P.M., Licensed Practical Nurse (LPN) C said when a medication was administrated the MAR should be initialed. If the medication was not administered the MAR should be noted as refused or unable to administer and documented in the resident's medical record. If the medication was not available, one should try the emergency kit for the medication. 4. During an interview on 6/17/25 at 1:54 P.M., the Director of Nursing (DON) said she would expect the Medication Administration Policy and Physician Order Policy to be followed as written. The DON said staff should initial the MAR after administering the medication and document if the medication was not administered. If the MAR was not initialed the medication was not given and the physician order was not followed. The Administrator agreed with the DON. MO00255890 MO00253530 MO00255054

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the safety of one resident with a diagnoses of diabetes and substance abuse, who left the building unnoticed for leave of absence (LOA). Staff last saw the resident on 3/31/25 at approximately 1:00 P.M. to 2:00 P.M. It was approximately seven hours until staff realized the resident was gone. Staff did not administer ordered afternoon and evening insulin (a hormone that helps your body use blood sugar for energy) injections (Resident #2). The sample was four. The census was 114. The Administrator was notified on 4/17/25 at 9:00 A.M., of the past non-compliance, which occurred on 3/31/25. The facility provided in-servicing for all staff regarding the facility's Resident's Outside Pass Policy and Elopement and Wandering Policy. The facility also updated Resident #2's care plan. The deficiency was corrected on 4/2/25. Review of the facility's Resident Outside Pass Policy (OSP), date 6/29/23, showed the following: -Purpose: -To ensure that the facility provides education and treatment/medications to the resident/resident's responsible party upon the resident's absence from the facility to ensure continuity of care while the resident is out of the facility therefore allowing for a successful out of the facility visit without negative effects on the resident. -Procedure: -If the resident is their own responsible party, the facility will obtain the following information: -a. Where to contact the resident in the event of an emergency; -b. Who will be transporting the resident; -c. How long the resident will be absent from the facility; -d. When the resident will return to the facility; -e. Any additional information that requires the facility to further provide care. -The charge nurse/designee will complete the OSP form prior to the resident leaving the facility; -In the event that the resident does not return to the facility at the time given to the facility, the facility will attempt to contact the resident/resident's responsible party to verify the resident's return. -If the facility is not able to contact the resident/resident's responsible party, the facility will then follow the CODE PURPLE (elopement while outside of the facility) procedures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Elopement and Wandering Resident's Policy, dated 6/12/24, showed the following: -Purpose: -This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person centered plan of care addressing the unique factors contributing to wandering or elopement risk; -Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. , an order for discharge or leave of absence) and/or any necessary supervision to do so. -Procedure for Locating Missing Resident: -1. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol. -Code White= Elopement from facility; -Code Purple= Elopement while outside the facility (on OSP or doctor's appointment, etc.); -2. The designated facility staff will look for the resident; -3. If the resident is not located in the building or on the grounds, Administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. The Administrator or designee should also notify the company's corporate office; -4. Director of Nursing (DON) or designee shall notify the physician and family member or legal representative; -5. Police will be given a description and information about the resident; include any photos; -6. All parties will be notified of the outcome once the resident is located; -7. Appropriate reporting requirements to the state survey agency shall be conducted. Review of Resident #2's face sheet, showed the following: -Diagnoses of diabetes and substance abuse in remission; -The resident was his/her own responsible party. Review of the resident's March Physician Order Summary, showed the following: -3/26/25, Insulin Aspart Injection (a rapid-acting insulin used to control blood sugar levels in people with diabetes) Solution 100 Unit/Milliliters (ml), inject seven units subcutaneously (involves injecting insulin into the fatty tissue layer beneath the skin) with meals for diabetes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurse's note, dated 3/31/25 at 12:50 P.M., showed late entry, the resident in bed resting, no distress noted. The resident received scheduled accucheck (blood glucose monitoring). The resident educated on the importance of signing out of facility if he/she wanted to go to the store or any other place outside of facility. This nurse had previously seen resident going to store across from facility. Review of the resident's Medication Administration Record (MAR), dated 3/31, showed blanks for the 4:00 P. M. and 8:00 P.M. dosages. Review of the resident March Order Summary, showed the following: -3/26/25, Insulin Glargine Subcutaneous (a long-acting type of insulin that works slowly, over about 24 hours) Solution, inject 25 units subcutaneously at bedtime for diabetes. Review of the resident's MAR, dated 3/31/25, showed a blank for the 8:00 P.M. dosage. Review of the facility's LOA book, located at the front receptionist desk, showed the following: -Date: 3/31/25; -Time: 3:17 P.M.; -Destination and/or contact number: friend; -Expected date/time return: blank; -Signature of person accepting responsibility: Resident's name; -Actual time of return: blank; -Staff Initials: blank. Review of the resident's nurse's note, dated 4/1/25 at 12:00 A.M., showed a late entry, At approximately midnight (12:00 A.M.) made aware that the resident did not notify the previous nurse on day shift nurse of going LOA. Night shift nurse who had also worked day shift said he/she made the resident aware that he/she always must sign out and notify nursing so that medications can be sent with the resident. Upon receiving this information, the DON was immediately made aware, as well as Administrator and code white for elopement activated per policy. The police were notified and case number received by this Registered Nurse (RN). The DON and Administrator was made aware. The resident's physician was phoned and awaited a call back. The resident was phoned, awaited a call back. The complete facility was searched for resident. The resident's room appears to have drawers cleared out of room and DON made aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's nurse's note, dated 4/1/25 at 3:30 A.M., showed staff spoke with resident's friend who said, Y'all not doing nothing for (him/her) anyway so why do (he/she) need to come back. Made him/her aware we would prefer to speak with the resident regarding his/her personal health care. The resident's friend became angry and said, I can't make (him/her) talk to you and hung up the phone. Several attempts were made by the staff to speak with the resident to encourage him/her to come pick up medications without success. Observation on 4/7/25 at 10:45 A.M., showed the resident in the common area, in a wheelchair and monitored by staff. During an interview at that time, the resident said he/she was fine and did not want to say where he/she had been. Review of the resident's nurse's note, dated 4/7/25, showed the following: -11:00 A.M., the resident arrived at the facility via staff transport via wheelchair. When resident arrived, upon cleaning him/her up, he/she had dried up bowel movement from the top of his/her perineal area all the way to his/her ankles. The resident has open area on the inner left and right thigh, that wasn't there when he/she left. This area is open and raw. He/She has a sore on the top of his/her left foot that has a scab on it; -11:06 A.M., The resident's physician was contacted with reference to resident's return to facility. Orders were received to send the resident out for evaluation. During an interview on 4/7/25 at 1:15 P.M., Certified Nurse Aide (CNA) A said he/she worked the night shift, 11:00 P.M. to 7:00 A.M. on 3/31 through 4/1/25. When he/she came on shift, he/she did rounds and the resident was not in his/her room. CNA A said he/she asked RN B if he/she had seen the resident. RN B did not know where the resident was. During an interview on 4/7/25 at 2:07 P.M., RN B said he/she came on shift at 2:00 P.M. on 3/31/25. RN B said he/she and did not get in report the resident was LOA. Towards the end of the shift, at an unknown time, CNA A came to him/her and said the resident was not in his/her room. RN B said he/she could not speak as to when the resident was last seen. RN B said the resident had a scheduled accu-check that evening but it was not completed. RN B did not think to locate the resident or find out if the resident was gone. RN B said he/she was recently inserviced on the facility OSP and Elopement Policy. During an interview on 4/8/25 at 9:45 A.M., Receptionist C said he/she worked the reception desk on the 3/31/25 evening shift, from 3:00 P.M. to 11:00 P.M. Receptionist C said the resident did not sign out with him/her before leaving. The protocol to go outside or LOA is to sign out at the nurse's station then sign out with the receptionist. The resident's name, time leaving and expected time of return should be on the sign out sheet. Receptionist C said sometimes a telephone number to be reached at will be left and sometimes not. The resident did not come back on his/her shift. It was about 10:00 P.M. or 11:00 P.M. before anyone realized the resident was gone. Receptionist C said he/she was inserviced on the facility's OSP and Elopement Policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265717	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Health Care Center	3645 Cook Ave Saint Louis, MO 63113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/8/25 at 12:37 P.M. CNA D said he/she was assigned to the resident on 3/31/25 on the 3:00 P.M. to 11:00 P.M. shift. When he/she came on shift, he/she did not see the resident. CNA D said in fact, he/she did not see the resident the entire shift. CNA D assumed the resident was out in the smoking area. About 9:00 P.M., he/she told RN B he/she had not seen the resident. RN B said he/she had not seen the resident either. CNA D should have tried to lay eyes on the resident during his/her shift. During an interview on 4/9/25 at 9:05 A.M., Licensed Practical Nurse (LPN) E said earlier during the day on 3/31/25, he/she educated the resident on signing out before leaving the facility. LPN E said the last time he/she saw the resident was about 1:00 P.M. to 2:00 P.M. and the resident was in bed. LPN E did not sign out the resident later in the day on 3/31/25. LPN E said when he/she came back to work the night shift, 11:00 P.M. to 7:00 A.M. on 3/31 through 4/1/25, CNA A said he/she did rounds and did not see the resident. LPN E asked RN B about the resident and he/she said the resident was maybe downstairs. RN B said he/she did not realize the resident was not in bed. LPN E said he/she was recently inserviced in the facility's elopement policy. During an interview on 4/7/25 at 10:19 A.M., the DON and Administrator said RN B should have tried to locate the resident and administer his/her insulin as ordered. The DON said a blank spot on the MAR means the medication was not administered. The DON and Administrator said the CNA and charge nurse should have been doing rounds at the beginning of the shift to locate all residents. The Administrator said the LOA form should have been filled out completely by the receptionist with the time leaving, expected time back, and possibly a number where the resident could be reached. The Administrator said she has already inserviced staff on the facility's OSP and Elopement Policies.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective pest control program to ensure resident rooms were free from mice (Resident #17, Resident #15 and Resident #16). The sample was 13. The census was 111. Review of the facility's Pest Control policy, last reviewed 5/14/24, showed: -Purpose: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents; -Definition: Effective pest control program is defined as measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitoes, flies, mice, and rats); -Policy: Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis. Review of the facility's pest control invoices showed the following: -5/13/25, Treated interior kitchen, laundry for spiders and occasional invaders. Service interior rodents' stations of rodent activity, gave blue boards to maintenance and fruit fly traps; -5/20/25, Treated interior kitchen, laundry for spiders and occasional invaders. Service interior rodents' stations and dropped off traps to maintenance for rodent activity; -5/27/25, Treated interior kitchen, laundry for spiders and occasional invaders. Service interior rodents' stations with minimal rodent activity at the time of service Review of video footage received by the Department of Health and Senior Services (DHSS) on 5/7/25, showed a mouse climbing down a window screen in a resident's room. Review of a photograph received by the DHSS on 5/7/25, showed three mice on a glue trap next to the resident's bed. 1. Review of Resident #17's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/11/25, showed the following: -No cognitive impairment; -No behaviors; -Supervision with activities of daily living; -Diagnoses of diabetes, depression and schizophrenia (a serious mental health condition that affects how people think, feel and behave). (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/16/25 at 7:15 A.M., the resident said he/she always saw mice in his/her room. The resident said he/she saw a mouse last night and one this morning. Observation of the resident's room at that time showed no signs of mice droppings. 2. Review of Resident #15's Facesheet, showed the following: -Date of admission: [DATE]; -Diagnoses of heart failure and acute kidney failure, During an interview on 6/16/25 at 10:42 A.M., the resident said he/she saw mice in his/her room all the time. Observation of the resident's room at that time, showed dirty sticky traps in the corner of the room. 3. Review of Resident #16's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -No behaviors; -Partial /Moderate assistance with ADLs; -Diagnoses of anemia(a condition where the body doesn't have enough healthy red blood cells to carry adequate oxygen to the body's tissues), high blood pressure, and schizophrenia. During an interview on 6/17/25 at 7:40 A.M., the resident said he/she saw mice in his/her room at night. The resident said last night a mouse ran across the floor in his/her room. Observation of the resident's room, showed no signs of mice droppings. 4. Observation on 6/2/25 at 8:36 A.M. of the Dietary Manager's Office located in kitchen, showed a dead mouse in a box trap. 5. During an interview on 6/2/25 at 1:30 P.M., Housekeeper (HK) A said he/she saw mouse droppings when cleaning resident rooms on the second floor each day. HK A said he/she reported the sightings to the Housekeeping Supervisor. HK A said he/she had been with the facility a little over a year and the mice concern had not gotten better. He/She had not been instructed to do anything differently to resident rooms after reporting the droppings. During an interview on 6/16/25 at 8:50 A.M., HK B said he/she cleaned resident rooms on the third floor. He/she would clean bathrooms and other areas and would often see mouse droppings. He/She reported this to the Housekeeping Supervisor. He/She had not been instructed to do anything differently to resident rooms after reporting the droppings. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 6/16/25 at 8:24 AM., the Maintenance Director said the facility just recently upgraded the service with the pest control company. Previously, the facility was responsible for maintaining the inside pest program. With the upgraded service, the pest control company would replace the mouse traps outside and now monitor the inside of the building to include changing out the inside traps and a detailed walk through. The pest control technician would be there on 6/17/25. This was the earliest they could come out. 7. During an interview on 6/17/25 at 2:04 P.M., the Administrator said the Maintenance Director was in responsible for the pest control program. The Administrator said she was not sure why it took so long to get the upgraded services. MO00253893 MO00253412 MO00255523 MO00253530 MO00253104 MO00255890 MO00255792