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	11/17/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated when another resident charged and hit him/her in the arm (Residents #1 and #2). The sample was six. The census was 112.The Administrator was notified on 10/3/25 at 10:43 A. M., of the past non-compliance, which occurred on 9/24/25. The facility provided in-servicing for all staff regarding the facility's abuse and neglect policy with emphasis on monitoring behavioral residents. The deficiency was corrected on 9/25/25. Review of the facility's Abuse and Neglect Policy, dated 6/12/24, showed the following:-Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-Definitions: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well- being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, showed the following:-Moderate cognitive impairment;-No behaviors;-No impairment to extremities; -Required partial to moderate assistance with activities of daily living (ADLs);-Diagnoses of anemia (a condition where there is a lower-than-normal amount of red blood cells or hemoglobin in the blood), high blood pressure and schizophrenia (a serious brain disorder that involves a distorted sense of reality, affecting thought processes, emotions, and behavior). Review of the resident's care plan, dated 9/24/25, showed the following:-Problem: The resident was involved in a resident-to-resident altercation with his/her roommate;Intervention: The resident will be moved to a different room and monitored closely when in common areas with other residents. Review of the resident's nurse's note, dated 9/24/25 at 11:03 P.M., showed the resident came to a chair in the hallway by nurse's station to sit. The resident's roommate walked calmly past desk then ran towards him/her hitting him/her on the arms. The resident kicked the other resident. The two were separated with assist from other staff. The resident said he/she did not know why his/her roommate had done that. The resident was assessed for injury. The resident had no swelling, open areas or skin discoloration. The resident said he/she is ok. A call was made to notify the Director of Nursing (DON) and Administrator. During an interview on 9/30/25 at 11:50 A.M., the resident said feels safe at the facility. He/She did not know why his/her former roommate attacked him/her. Review of Resident #2's face sheet, showed his/her diagnoses of morbid obesity and schizophrenia. Review of the resident's care plan, dated 9/24/25, showed the following:-Problem: The resident was involved in a resident-to-resident altercation with his/her roommate where he/she was the aggressor;-Intervention: The resident and his/her roommate will be separated. The resident will be monitored when in common area. The resident will be placed on one-on-one protective oversight until seen by psychiatrist. Review of the resident's nurse's notes, dated 9/24/25, showed the following:-11:03 P.M., the resident walked past the nurse's station then ran to his/her roommate (who was) sitting in a chair in the hallway. The resident started hitting him/her on his/her arms. The resident's roommate kicked him/her in the arm. Both residents were separated. The resident continually looked for the other resident. The resident was removed from the view of his/her roommate. The resident went into his/her room scratching and biting on his/her arm. The resident showed staff scrape to left scalp and temporal area. There was no active bleeding. The resident was threatening to hit his/her head on the wall and cut his/her throat The resident was encouraged out of his/her room to be monitored. The police and ambulance called for transport to the hospital. The resident refused treatment for area;-11:18 P.M., spoke with the resident's sibling, guardian, and left message with the resident's family member. The resident's doctor was called and reported behaviors and self-inflected injuries. The resident was sent out to hospital. The resident sat calmly with police awaiting ambulance. The DON and Administrator were called;-11:48 P.M., the ambulance here for the resident. The resident ambulated and got on stretcher without assist. The police escorted with resident. During an interview on 9/30/25 at 7:43 A.M., the resident said he/she was doing fine. The resident

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide services and/or treatment to increase or prevent reduction of range of motion. The facility failed to ensure one resident received recommended restorative therapy exercises after being discharged from skilled nursing therapy (Resident #3). The sample was six. The census was 112.Review of the facility's Restorative Nursing Program, dated 4/30/24, showed the following:-Purpose: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level;-Definition: Restorative Nursing Program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning;-Policy: -Restorative Nursing:-1. Cognitive and physical functioning of all residents will be assessed in accordance with the facility's assessment protocols;-2. The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment, goals, and preferences;-3. The discharging therapist, Restorative Nurse, or designated licensed nurse will communicate to the appropriate restorative aide, the provisions of the resident's restorative nursing plan, providing any necessary training to carry out the plan;-4. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting in the Electronic Health Record. Review of Resident #3's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/23/25, showed the following:-No cognitive impairment;-No moods or behaviors;-No impairment to extremities;-Partial to moderate assistance with activities of daily living (ADL);-Diagnoses of congestive heart failure, high blood pressure and hemiplegia (a form of severe, complete paralysis on one side of the body, including the face, arm, and leg, typically caused by a brain or spinal cord injury). Review of the resident's Discharge Occupational Therapy Summary, dated 2/21/25, showed the following:-Discharge Recommendations: Resident to be discharged to this skilled nursing facility with recommendations of Restorative Nursing Program. Review of the resident's care plan, dated 7/10/25, showed the following:-Problem: Resident has an ADL self-performance deficit with regards to impaired balance;-Intervention: Active Range of Motion (AROM) program resident to complete bilateral upper extremities (BUE) strength with three to six pound weights at 20 repetitions times three or as tolerated. Review of the resident's September Order Summary Report, showed an order, dated 7/18/25, for Restorative AROM program for resident to complete BUE strength with three to six pound weights at 20 repetitions times three or as tolerated every Monday. Wednesday and Friday. During an interview on 9/30/25 at 1:59 P.M., the resident said he/she has not been receiving restorative therapy with weights. The resident said he/she would like it to help build his/her strength. Review of the Restorative Nursing Program binder, showed no documentation of the weights order recommendation. During an interview on 10/1/25 at 9:52 A.M., Certified Nurse Aide (CNA) C said he/she has only been the restorative aide for about two- and one-half months. CNA C said the therapy department will give the order for restorative therapy to the Assistant Director of Nursing (ADON) and he/she will give him/her a list of orders for each resident. CNA C was not aware of the resident having order to lift weights. During an interview on 10/1/25 at 10:05 A.M., the ADON said there was another person was over saw the restorative program and he/she resigned about three weeks ago. The ADON said this is when she took over. The ADON got a list of orders from the Therapy Director. The ADON said this order must have been overlooked. During an interview on 10/1/25 at 10:12 A.M., the Director of Nursing (DON) said she expected all restorative orders obtained from the Therapy Director to be completed and ordered or recommended. The DON did not know why this order was overlooked. During an interview on 10/3/25 at 10:47 A.M., the Administrator said she expected the restorative orders to be followed as written. The Administrator said there has been turnover with the restorative aide position. 2623652

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure one resident was provided with adequate supervision and staff oversight. On 9/23/25, a resident was left unsupervised in the back unsecured area during a smoking break and the resident wandered away from the facility (Resident #1). The sample was six. The census was 112. The Administrator was notified on 10/3/25 at 10:43 A.M., of the past non-compliance, which occurred on 9/23/25. The facility provided in-servicing for all staff regarding the facility's elopement and wandering policy with emphasis on monitoring residents during smoke times. The deficiency was corrected on 9/25/25. Review of the facility's Elopements and Wandering Residents policy, last reviewed on 6/12/24, showed:-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;-Definitions: Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so;-Policy: Preventing Elopements: -1. The facility is equipped with door locks/alarms to help avoid elopements; -2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner; -3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary; -4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: -1. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team; -2. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan; -3. Interventions to increase staff awareness of the resident's risk, modify the resident's behaviors, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff; -4. Adequate supervision will be provided to help prevent accidents or elopements; -5. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly; -6. The effectiveness of interventions will be evaluated and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff;-Procedure for Locating Missing Resident: -1. Any staff member becoming aware of a missing resident will alert personnel using approved protocol: Code [NAME] = Elopement from facility; -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 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 #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, showed the following:-Moderate cognitive impairment;-No behaviors;-No impairment to extremities; -Required partial to moderate assistance with activities of daily living (ADLs);-Diagnoses of anemia (a condition where there is a lower-than-normal amount of red blood cells or hemoglobin in the blood), high blood pressure and schizophrenia (a serious brain disorder that involves a distorted sense of reality, affecting thought processes, emotions, and behavior). Review of the resident's nurse's note, dated 9/23/25, showed the following:-10:29 P.M., the resident did not return to floor for night medications. Areas of the first floor searched including bathrooms and patio areas. Other resident rooms, showers rooms, and bathrooms on the second and third floors were checked. Other residents were asked about the resident, and none had seen him/her since the last smoke break. Staff said they had seen the resident on and off the floor throughout evening, sitting in dining room and in the lobby. The resident was engaging in activities in activity room until it closed. The Director of Nursing (DON) was called, and a message was left;-10:59 P.M., Areas outside of the building were checked for the resident. The Assistant Director of Nursing (ADON) was called and reported the resident was unable to be found. Spoke with the DON and the Administrator was called. The staff drove around the outer streets around the facility. Called to speak with the resident's family and they had not heard from the resident. The

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure recipes were followed while preparing pureed meals. The facility had eight residents on pureed meals. The sample was six. The census was 112. Review of the facility's Dietary Food Preparation Policy, dated 7/5/23, showed the following:-Standardized Recipes: Standardized recipes will be used for all product prepared;-Procedure: -Use standardized recipes provided with menu cycle; -The Dietary Manager will monitor and check routinely the cooks' use of recipes. If favorite recipes are added to the recipe file, they must be written, standardized and approved by the Registered Dietitian; -Pureed recipes are found in the recipe binder. Observation on 9/30/25 at 12:20 P.M., showed [NAME] A took four, four-ounce scoops of diced chicken, placed it in a blender and blended for approximately 10 seconds, then added one slice of white bread and continued to blend. While blending, [NAME] A added water. [NAME] A said he/she did not know how much water he/she was adding and blended for approximately one minute. Observation after blending, showed the chicken breast to have small lumps of meat and was not smooth. [NAME] A poured the mixture into a tin pan. [NAME] A did not have a recipe present during the preparation. Review of the facility's Pureed Herb Roasted Chicken recipe, dated 2024, showed the following:-10 Servings: two tablespoons of chicken base, two cups of water and one pound and 14 oz of herb roasted chicken;-Dissolve chicken base in water to make chicken broth. Place prepared chicken in a washed and sanitized food processor. Gradually add broth and blend until smooth. Observation on 9/30/25 at 12:25 P.M., showed [NAME] A took six, four-ounce scoops of diced potatoes and placed them into a blender and blended. While blending, he/she added water. [NAME] A said he/she did not know how much water he/she was adding and blended for approximately 40 seconds. Observation after blending showed the potatoes were smooth. During an interview on 9/30/25 at 12:26 P.M., [NAME] A said he/she has been at the facility for 14 years and he/she did not feel he/she needed to look at a recipe. Observation on 10/1/25 at 1:10 P.M, showed [NAME] B took ten, eight-ounce scoops of diced carrots, five slices of white bread and one quarter cup of melted margarine and placed it into a blender and blended for about one minute. Observation after blending showed a smooth consistency. [NAME] B had the recipe present during meal preparation. During an interview on 10/1/25 at 1:12 P.M, [NAME] B said he/she always added bread to make the mixture smooth. Review of the facility's Pureed Candied Carrots recipe, dated 2024, showed the following:-10 servings: One quart and one cup of candied carrots and a quarter cup of margarine. Description: No Bread;-Place prepared vegetables and margarine in a sanitized food processor and blend until smooth. During an interview on 10/1/25 at 2:03 P.M., the Dietary Manager (DM) said he/she could not find a recipe for mashed potatoes. DM said cooks should look at recipes during meal preparation. DM said he/she did not know why the cooks did not follow the recipe or have them present during meal preparation. During an interview on 10/1/25 at 2:06 P.M., the Regional Dietary Manager (RDM) said he/she expected all recipes to be followed as written. RDM said this will ensure the proper nutrition for the residents. RDM said the recipes are kept in a binder in the kitchen for reference. During an interview on 10/3/25 at 10:50 A.M., the Administrator said the recipes should be present and followed during meal preparation. 2623652