

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265717	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2026
NAME OF PROVIDER OR SUPPLIER Grand Manor Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to follow their abuse policy when staff failed to report a resident to resident altercation to Administration, resulting in a failure to conduct a thorough investigation into the altercation, in which one resident sustained an injury underneath his/her eye (Residents #1 and #2). The sample was four. The census was 111. 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:-Physical Abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior;-Procedure for Response and Reporting Allegations of Abuse, Neglect and Exploitation:-Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline without fear of retaliation;-When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated:--The Licensed Nurse will:---Respond to the needs of the resident and protect him/her from further incident;---Notify the Administrator or designee;---Complete an incident report if indicated;---Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse;--The Administrator or designee will:---Administrator/Designee will complete an administrative investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, any unexpected medical emergency, or when the administrative staff feel uncomfortable in any situation involving resident care or treatment or staff treatment;---Refer to the State Operations Manual (SOM) for reporting and utilize the Abuse-Neglect Reporting Decision Tree to assess the particular incident. Should the incident be a reportable event, notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than two hours after discovery or forming the suspicion;---The administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including the facts that prove or disprove the alleged situation occurred, the plan of correction or action by the administrative staff, all statements attached from residents and staff involved and any</p> <p>(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265717	If continuation sheet Page 1 of 3

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>training or education that the administration feels needs to be provided to staff or residents to ensure education has been provided to prevent future similar situations;---The administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician was made aware, the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated, and the plan of care was updated to reflect the change in medical or behavioral status;---The facility Director of Nursing (DON)/Designee will ensure all clinical details and supportive plan of care interventions are completed for the administrative investigation;---Within five working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/5/25, showed the following:-Moderate cognitive impairment;-No moods or behaviors exhibited;-Diagnoses include anemia (a condition where the blood lacks enough healthy red blood cells to carry adequate oxygen to the body) and end stage renal disease (ESRD, the final permanent stage of chronic kidney disease where kidneys can no longer function on their own to filter waste and excess fluids). Review of the resident's nurse's notes, showed the following:-On 1/26/26 at 9:33 P.M., staff documented at about 4:20 P.M., Resident #1 was sitting at the television area. Resident #2 was seen hitting Resident #1 with his/her walking cane. Resident #1 sustained a slight bruise/cut on the side of his/her left eye. The area was cleansed with wound cleanser, triple antibiotic ointment was applied and covered with a bandage. Resident #1's family and the DON and Assistant Director of Nursing (ADON) were made aware;-On 1/28/26 at 12:14 P.M., staff documented the resident was in bed resting. The resident complained of a headache and was given medication for the pain. The resident said he/she wanted to go hospital to be seen following altercation with another resident. The resident was transferred to the hospital for further evaluation. The resident's family was notified upon resident being transferred. A message was left for the resident's physician and the DON was made aware. Review of the resident's care plan, showed no documentation regarding the resident-to-resident altercation. Review of Resident #2's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-No behaviors exhibited;-Diagnoses included anemia, congestive heart failure, high blood pressure, and Alzheimer's disease. Review of the resident's nurse's note, dated 1/26/26 at 9:21 P.M., showed staff documented at about 4:20 P.M., the resident was seen at the television area hitting another resident with his/her walking cane. The residents were separated and Resident #2 was taken to the nursing station. A message was left for the resident's family and the DON and ADON were made aware. Review of the resident's care plan, showed no documentation regarding the resident-to-resident altercation. During an interview on 2/2/26 at 12:40 P.M., the resident said he/she was in a fight in the city a while ago. The resident said he/she did not remember any other altercation. Review of Resident #4's quarterly MDS, dated [DATE], showed the resident had moderate cognitive impairment. During an interview on 2/3/26 at 7:55 A.M., Registered Nurse (RN) A said he/she was giving care to a resident in their room when he/she overheard a loud commotion going on and stepped outside the room to see what was happening. He/She heard Resident #4 asking Resident #2 why he/she hit Resident #1 with his/her cane. RN A did not see the altercation; however, Resident #1 had a cut under his/her left eye. RN A took Resident #2 to the nursing station and called the DON, the physician and family members. He/She was not asked to write a statement regarding the altercation. During an interview on 2/3/26 at 9:05 A.M., Resident #4 said Resident #1 was watching television in the common area and Resident #2 came up and started hitting Resident #1 with his/her cane. There was no exchange of words</p> <p>(continued on next page)</p>		

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