

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2026
NAME OF PROVIDER OR SUPPLIER  Creve Coeur Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  1127 Timber Run Drive Saint Louis, MO 63146	

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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident received gastrostomy tube (g-tube, a sterile tube surgically inserted through the abdomen into the stomach, used to provide nutrition and fluids) feedings and fluids as ordered. The facility identified three residents with tube feedings, one of whom was sampled and problems were found (Resident #1). The census was 80. Review of the facility's Tube Feeding, policy, dated 3/28/25, showed the following:-Policy: It is the policy of the facility of the facility that residents' nutritional needs will be met by tube feeding, when oral consumption is not possible and the resident consents;-Procedure included:-Check the physician's order to determine type and rate of feeding;-Set the pump for the rate ordered;-Start the pump. Review of the facility's Obtaining and Following Physician Orders policy, dated 7/2017, showed the following:-Policy: It is the policy of the facility that physician orders will be obtained by licensed personnel and followed. If those orders are not followed for any reason, the physician and Director of Nurses (DON) will be promptly notified;-Procedure included:-When it is discovered that a physician's order was not implemented, the nurse shall immediately notify the physician of this failure and document the omission on an accident and incident form. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/14/25, showed the following:-Diagnoses included high blood pressure, stroke, and dementia;-Short and long-term memory loss;-Required total staff assistance for all activities of daily living (ADLs);-Feeding tube: Yes;-Received 51% or more of total calories and fluids per feeding tube. Review of the resident's care plan, updated 1/29/26, showed the following:-Problem: Resident at risk for alteration in nutrition and hydration related to (r/t) difficulty swallowing and history of failed swallow test;-Goal: Nutritional and weight will remain stable;-Approach: Diet as ordered. Monitor labs and weight;-Problem: Resident is at risk for complications related to g-tube;-Approaches: Provide tube feeding as ordered. Water flushes as ordered. Review of the resident's physician order sheet (POS), dated 3/2026, showed the following:-An order, dated 1/15/26, for tube feeding, Jevity 1.5 Cal (calorie dense, high protein, fiber fortified liquid formula), 45 milliliters (ml) per hour for 23 hours;-An order, dated 1/15/26, to flush g-tube with 150 ml of water every four hours. Observation on 3/2/26, showed the following: -At 10:38 A.M., the resident not in his/her room. Jevity 1.5 Cal and water hung on the pole next to the resident's bed;-At 10:48 A.M., the resident sat in the hallway across from the nurse's station without his/her tube feeding or water. Registered Nurse (RN) A sat at the nurse's station in full view of the resident;-At 1:45 P.M., the resident lay in bed. Jevity 1.5 Cal and water hung on the pole next to the resident's bed, not attached to the resident. During an interview, on 3/2/26 at 1:05 P.M., Certified Nurse Aide (CNA) B said he/she got the resident up at around 9:00 A.M. and placed him/her at the nurse's desk. During an interview, on 3/2/26 at 1:50 P.M., RN A said he/she was the charge nurse taking care of the resident. Staff brought the resident out to the nurse's station this morning around 9:00 A.M. When asked about the resident's tube feeding, RN A said it was ordered to begin this afternoon at 3:00 P.M. During the interview, RN A reviewed the resident's POS and said the resident's tube feeding should have been restarted once the resident was gotten out of bed. He/She would (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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F 0693  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	notify the physician of the error. During an interview on 3/2/26 at 2:25 P.M., the DON said she expected nurses to follow the resident's tube feeding orders as written. The nurse should be aware of the residents on his/her floor with tube feedings and what their orders are. During an interview on 3/2/26 at 2:30 P.M., the Administrator said she expected the nurse to infuse the resident's tube feeding as ordered.		