STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265720	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creve Coeur Manor	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff transcribed physician orders and administered medications as ordered for one resident (Resident #1) and to hold medication in accordance with parameters ordered by the physician for one resident (Resident #2). The sample was 3. The census was 79.Review of the facility's Physician's Orders policy, dated February 2020, showed the following:-Elements of the medication order: Name of the medication, strength of the medication, dosage, time or frequency of administration ,route of administration if other than oral, quantity or duration (length) of therapy, diagnosis or indication, medication allergy;-Documentation of the medication order:-1. The physician's new orders may be received on the admission Physician's Order Form, by telephone or handwritten on the Physician Order Sheet (POS). All drug orders received via transfer sheet must be verified by the attending physician and transcribed onto the POS;-2. Each medication order is documented in the resident's medical record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet, the Medication Administration Record (MAR) and the Treatment Administration Record (TAR);-3. The following steps are initiated to complete documentation: --Clarify the order;--Enter the orders on the medication order and fax to the pharmacy;--Transcribed newly prescribed medications on the MAR or TAR. 1. Review of Resident #1's medical record, showed the following:-readmission date of 02/16/26;-Diagnoses included high blood pressure, stroke, and heart failure. Review of the resident's POS, showed an order, dated 02/16/26, for bisoprolol fumarate (medication used to treat high blood pressure) 5 milligrams (mg), give 1/2 tablet per gastrostomy (a sterile tube surgically inserted through the abdomen into the stomach, used to provide nutrition, medication, and fluids) once daily. Review of the resident's MAR, dated 02/16/26 through 02/28/26, showed no order for bisoprolol fumarate. Review of the resident's MAR, dated 03/01/26 through 03/31/26, showed no order for bisoprolol fumarate. Review of the resident's MAR, dated 04/01/26 through 04/30/26, showed no order for bisoprolol fumarate. Review of the resident's progress notes, showed no documentation regarding the bisoprolol fumarate. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated, 04/16/26, showed the following:-Short and long term memory loss;-Total dependence for all activities of daily living (ADL). Review of the resident's care plan, in use at the time of survey, showed no documentation regarding high blood pressure medication. Review of the resident's MAR, dated 05/01/26 through 05/21/26, showed no order for bisoprolol fumarate. During an interview on 05/21/26 at 3:40 P.M., the Assistant Director of Nurses (ADON) said she had passed medications to the resident several times as the charge nurse and was unaware of the order for bisoprolol fumarate. During an interview on 05/21/26 at 3:41 P.M., the Director of Nurses (DON) said she had passed medications to the resident several times. She was unaware of the order for bisoprolol fumarate 5 mg once a day. She had never seen the medication on the medication cart. A problem occurred when the medication was ordered and transcribed. She expected all medications to be administered as ordered. During an interview on 05/21/26 at 3:42 P.M., the Administrator said upon admission, she expected all admission paperwork to be completed and reviewed for accuracy. She expected all medications to be administered as ordered. 2. Review of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's quarterly MDS, dated [DATE], showed the following:-Diagnoses included high blood pressure, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and high cholesterol;-Alert and oriented to name and place. Review of the resident's care plan, updated 03/31/26, showed the following:-Problem: Risk for cardiovascular problems related to high blood pressure and high cholesterol;-Approaches: Monitor vital signs per protocol. Notify physician of changes. Observe for signs and symptoms of cardiovascular problems. Observe effectiveness of medications. Review of the resident's POS, showed an order, dated 01/07/26, for metoprolol succinate 50 mg by mouth once a day. Hold if systolic blood pressure (SBP) is less than 100. Hold if diastolic blood pressure (DBP) is less than 60 and hold if heart rate (HR) is less than 60. Review of the resident's MAR, dated 05/01/26 through 05/15/26, showed the following:-An order, dated 01/07/26, for metoprolol succinate 50 mg by mouth once a day. Hold if systolic blood pressure (SBP) is less than 100. Hold if diastolic blood pressure (DBP) is less than 60 and hold if heart rate (HR) is less than 60;-Heart rate on 05/01/26 through 05/06/26, 05/08/26 through 05/11/26, 05/14/26 through 05/17/26, and 05/19/26 through 05/21/26 documented as below 60. Staff documented metoprolol succinate administered on these dates;-No documentation the physician was notified of below parameter heart rates. Review of the resident's progress notes, dated 05/01/26 through 05/21/26, showed no documentation the physician was notified of the resident's below parameter heart rates. During an interview on 05/22/26 at 2:05 P.M., Certified Medication Technician (CMT) A said he/she worked the dayshift and had administered medication to the resident. He/She would hold the resident's blood pressure medication if the resident's heart rate was below the parameter. He/She didn't recall whether he/she notified the nurse of the resident's low heart rate. During an interview on 05/21/26 at 3:41 P.M., the DON said she expected the CMT to have notified the nurse of the resident's low heart rate. The nurse should have notified the physician and clarified the order. During an interview on 05/21/26 at 3:42 P.M., the Administrator said she expected physician orders to be followed as ordered. 2993902