

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Quarters at Des Peres, The		STREET ADDRESS, CITY, STATE, ZIP CODE 13230 Manchester Road Des Peres, MO 63131	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff documented the reason for residents' transfer or discharge in the medical record. The facility failed to record the medically justified reason for 3 residents who were transported to the hospital after a change in condition (Residents #4, #1, and #10). The sample was 20. The census was 127. Review of the facility's Discharge and Transfer-Involuntary policy, last reviewed 10/7/21, showed:-Policy: Transfer and discharge includes movement of a resident to a bed outside of the 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. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless specific criteria, as outlined below, are met;-Procedure: -1. The facility reserves the right to transfer a resident deemed acutely ill by the physician to a hospital or other facility better equipped to meet the resident's health care needs;-2. A written or telephone order is required from the attending physician for the discharge of a resident, except in emergency situations;-3. The Interdisciplinary team (IDT) and the resident's physician must document in the resident record when a resident is transferred or discharged ;-4. The facility will provide sufficient orientation to residents to ensure safe and orderly transfer or discharge from the facility including an opportunity to participate in the decision of where to transfer;-6. See Discharge Plan/Summary policy for information on the Discharge Summary and discharge documents;-7. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and the resident representative or legal representative that specifies the duration of the bed-hold policy and the facility's policies regarding bed-hold;-9. The resident's clinical record shall be completed and forwarded to the medical records department following the discharge, transfer, or death of the resident. 1. Review of Resident #4's face sheet, showed: -admission: [DATE];-Diagnoses included dependence on renal dialysis (the process of filtering the blood for individuals with kidney failure), high blood pressure, diabetes, cognitive communication deficit, weakness and need for assistance with personal care. Review of the resident's care plan, dated 8/20/25, showed: -Focus: The resident needs dialysis three times a week related to renal failure, created 8/20/25;-Goal: -The resident will have immediate intervention should and sign or symptoms of complications from dialysis occur through the review date, created 8/20/25; -The resident will have no signs or symptoms of complications from dialysis through the review date, created 8/20/25;-Interventions: -Check and change dressing daily at access site. Document, created 8/20/25; -Encourage resident to go for the scheduled dialysis appointments. Resident receives hemodialysis in facility Tuesday, Thursday and Saturday, created 8/20/25; -Monitor and document report to physician signs and symptoms of depression. Obtain order for mental health consult if needed, created 8/20/25; -Monitor, document and report as needed (PRN) any signs and symptoms of infection to access site: Redness, swelling, warmth or drainage, created 8/20/25; -Monitor, document and report PRN for signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa (moist, inner lining of mouth), changes in heart and lung sounds, created 8/20/25. Review of the resident's progress notes, showed: -On 8/28/25 at 12:53 P.M., IDT: Resident receives skilled services physical therapy (PT) occupational therapy (OT). Resident was sent to hospital this A.M. and remains there at this time;-On 8/27/25 at 11:36 A.M., skin wound note;-No progress note documenting the medical reason resident went to the hospital. Review of the medical record, showed:-No situation, background, appearance, review and notify (SBAR) assessment completed;-No transfer form completed;-No documentation of the reason why the resident was transported to the hospital. Review of the census, dated 8/28/25 at 1:03 P.M., showed resident still active and not discharged . Review of the resident's order summary, showed no order on 8/27/25 or 8/28/25 to send resident to the hospital for evaluation and treatment. During an interview on 8/29/25 at 9:05 A.M., Certified Medication Technician (CMT) A said he/she did not work the previous day so if the resident went to the hospital, he/she did not know why the resident was sent to the hospital. CMT A said he/she was not aware the resident went to the hospital the previous day. CMT A did not get anything in report about the resident being in the hospital. During an interview on 8/29/25 at 9:09 A.M., Licensed Practical Nurse (LPN) B said he/she did not get information about the resident in report about the resident going to the hospital or why. LPN B said if a resident is sent to the hospital, the nurse calls the physician, the family and Director of Nursing (DON) LPN B said the reason and condition of the resident when they are sent out would be documented in the resident's		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide acceptable nursing services by failing to report the results of an immediate (STAT) x-ray for one resident (Resident #5) who had complaints of shortness of breath (SOB). Two days after the x-ray, the resident requested to go to the hospital, the hospital found a large pleural effusion (condition where excess fluid accumulates in the pleural space, the thin membrane that separates the lungs from the chest wall) and a chest tube (drains access fluid) had to be placed. Additionally, the facility failed to administer intravenous (IV, method of administering fluids, medications, or nutrients directly into the bloodstream through a needle or catheter inserted into a vein) medications as ordered for two residents (Resident #3 and Resident #12). The census was 127. Review of the facility's Change of Condition policy, last reviewed 2/6/25, showed: -Policy: The attending physician/physician extender (Physicians, Nurse Practitioners, & Physician's Assistants, or Clinical Nurse Specialist) and the Resident Representative (RR) will be notified of a change in a resident's condition, per standards of practice and federal and/or state regulations; -Procedure: -1. Guideline for notification of physician and RR (not all inclusive): -Significant change in medical or cognitive baseline; -Accident or incident; -Abnormal lab results in conjunction with a change in condition; -2. Document in the Interdisciplinary Team (IDT) Notes: -Resident change of condition; -Physician/Physician Extender Notification; -Notification of RR. Review of the facility's Physician Orders policy, last reviewed 9/28/22, showed: -Policy: To provide guidance and ensure physician orders are transcribed and implemented in accordance with professional standards, state and federal guidelines; -Procedure: -Physician orders shall be provided by licensed practitioners (Physicians, Nurse Practitioners, & Physician's Assistants) authorized to prescribe orders; -Orders must be recorded in the medical record by the licensed nurse authorized to transcribe such orders; -Physician orders must be documented clearly in the medical record. The required components of a complete order: -Date and time of order; -Name of practitioner providing order; -Name and strength of medication or treatment; -Quantity and duration; -Dosage and frequency; -Route of administration; -Indication and diagnosis; -Stop Date, if indicated; -Physician orders that are missing required components, are illegible or unclear must be clarified prior to implementation; -Physician Order Sheet (POS) will be maintained with current physician orders as new orders are received. Discontinued (DC) orders will be marked as discontinued with the date, and all new orders will be written in the appropriate area on the POS with the date the order was received; -Physician orders will be transcribed to the appropriate administration record, Medication Administration Record (MAR) or Treatment Administration Record (TAR); -Medications will be ordered from the pharmacy to ensure prompt delivery. Medications available from the Emergency Drug Supply (E-Kit) or Automatic Dispensing Unit (ADU) shall be utilized for the first dose until a supply arrives from pharmacy, if available. Review of the facility's Infusion Therapy Medication Administration policy, dated 12/17, showed: -Procedures: -M. Document in Nursing Progress Notes: -1. Date; -2. Time; -3. Flushing agent; -4. Medication, solution; -5. Infusion rate; -6. Site assessment, complications, if any; -7. Patient response to procedure; -8. Type of solution and medication; -9. Duration of medication infusion; -10. Any untoward reactions. 1. Review of Resident #5's face sheet, showed diagnoses included hypertensive heart failure, congestive heart failure, peripheral vascular disease and weakness. Review of the resident's care plan, in use during survey, showed: -Focus: Resident prefers independent leisure; -History/potential for behavior problem: Alcohol consumption to excess; -The resident is at risk for falls, deconditioning, gait/balance problems and episodes of incontinence; -Resident has the potential for impaired skin integrity related to a history of wounds. Review of the resident's progress notes, showed: -On 8/2/25 at 1:53 P.M., Nurse was called to patient (pt) room related to fall, nurse observed pt walker facing the door and pt on the floor behind the walker. Nurse observed wet pull up. Shoes noted on pt. When asked what happened, pt replied I was headed to the bathroom when I lost my balance. Range of motion completed, aides and nurse used the Hoyer (mechanical lift) to lift pt up to wheelchair. Physician and resident representative aware; -On 8/3/25 at 11:06 A.M., Complaints of pain noted, as needed (PRN) oxy (pain medication) given as ordered hour later, effective. Patient on incident follow up for fall. Patient alert x 4 (to person, place, time and situation), walks with walker; -On 8/4/25 at 12:20 P.M., late entry: Resident was discussed during the Interdisciplinary Team (IDT) meeting in relation to a recent fall while self-transferring to the bathroom. Fall occurred without apparent injury; however, risk for future falls remains a concern. Current interventions in place to reduce fall risk include PT/OT reeducation on using the call light to ask for		

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately assess resident falls by ensuring residents received treatment and care in accordance with acceptable standards of practice when the facility failed to accurately complete a post (after) fall 72 hour monitoring report (neurological (neuro) evaluation - pulse (P), respiration (R), and blood pressure (BP) measurements; assessment of pupil size and reactivity; and equality of hand grip strength) if the fall was unwitnessed or if the resident had an incident hitting their head for one resident (Resident #10). The facility failed to complete incident follow up documentation (IFU) for 72-hours. The facility also failed to update the resident's care plan timely. The facility failed to offer as needed (PRN) pain medications post fall. The facility also failed to ensure x-rays were completed for the resident's right extremities in accordance with physician's orders. The facility failed to document the resident's transfer to the hospital for further assessment following the fall. The sample was 20. The census was 127. Review of the facility's Accident and Incident Documentation and Investigation, dated 8/30/18, showed:-Policy: Accidents and/or Incidents involving Residents will be investigated and documented on an Incident Report entry in the EHR. An Incident is defined as an occurrence which is not consistent with the routine operation of the Facility or the routine care of a particular Resident. Accidents and Incidents will be analyzed for trends or patterns to enable the Facility to enhance preventive measures to reduce the occurrence of Incidents;-Procedure: The Licensed Nurse assigned at the time of the resident care accident/incident is responsible for conducting an investigation of the circumstances surrounding the Accident/Incident, and for notifying the Supervisor, Director of Nursing, and/or the Administrator as appropriate;-The Licensed Nurse at the time of the Incident is responsible for initiating/completing the Incident Report, ensuring that all items have been completed as applicable to the Accident/Incident;-The Licensed Nurse at the time of the Incident is responsible for documenting the incident in the resident's medical record, in accordance with the guidelines below and set forth in the incident report;-If the incident/accident is related to a visitor; documentation in the medical record will not be applicable;-Notification and documentation: The Licensed Nurse shall document the incident and notify the supervisor and Director of Nursing for follow through as needed (not applicable with visitor Incident);-The Licensed Nurse may complete a nurses' note and update the Resident Care Plan as needed (not applicable with visitor incident);-The Nurse's notes may contain the following documentation:-Clear objective facts of what occurred;-An Evaluation of the resident's condition at the time of the accident/incident may include a description of the resident, vital signs, and other physical characteristics apparent as a result of the accident/incident;-Any treatment provided;-Notification or attempts to notify the resident's physician, family, and/or legal representative, or any other health care professional or individuals involved with the resident's care;-The charge nurse's signature, date, & time of the documentation;-Note: If a Visitor accident/incident occurs, medical record documentation will not apply.-The Administrator/ Director of Nursing will notify the State Department of Health in accordance with Reporting Guidelines in the event the accident/incident is a reportable occurrence;-Accidents/Incidents will be reviewed as part of Quality Assurance and Quality Improvement (QAPI);-Report completion: Incident Report will be completed in the Electronic Medical Record (EMR);-In the event the computer is down paper copies of an incident report will be available. Review of Resident #10's face sheet, showed:-admitted on [DATE];-discharged on 8/25/25;-Diagnoses included cerebral infarction (stroke), posterior reversible encephalopathy syndrome (PRES, rare neurological disorder characterized by reversible brain swelling in the back part of the brain), hemiplegia (weakness on one side of the body) and hemiparesis following cerebral infarction, anemia (iron deficiency) and muscle weakness. Review of the resident's nursing admission evaluation and baseline care plan, dated 8/21/25, showed:-General appearance: Blank;-Vital signs: Blank;-Head, eyes, ears, nose and throat (HEENT): Blank;-Respiratory/chest: Blank;-Cardiac/circulation: Blank;-Gastrointestinal/bowel: Blank;-Genitourinary/bladder: Blank;-Skin: Blank;-Pain: Blank;-Extremities/Range of motion: Blank;-Functional abilities/self care: Blank;-Functional abilities/mobility: Blank;-Mobility devices: Blank;-Health conditions/special treatments: Blank;-Medications: Blank;-Medical conditions: Blank;-Physician orders: Blank;-Dietary/nutritional status: Blank;-Therapy: Blank;-Social Services: Blank;-Plan of care: Blank;-Baseline care plan review: Blank. Review of the resident's admission fall risk assessment, dated 8/21/25, showed:-Level of consciousness/mental state: Blank;-History of falls (past three months): Blank;-Ambulation/elimination status: Blank;-Vision status: Blank;-Gait/ balance: Blank;-Systolic blood		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to follow their policy for four sampled residents who received dialysis (the process of filtering the blood for individuals with kidney failure). Resident #18 had an inconsistent order for dialysis days, with the order showing Monday, Wednesday and Friday and the resident received dialysis on Tuesday, Thursday and Saturday, and the care plan did not list the scheduled chair time and location for dialysis treatment. Additionally, the facility failed to contact and document the notification to the physician and resident representative (RR) when his/her dialysis treatment ended early. Resident #2 did not have physician orders that included the location for the dialysis services and the scheduled dialysis chair time and failed to ensure the dialysis services had been addressed on the resident's individual care plan. The facility failed to complete the dialysis communication forms (vital signs taken prior to dialysis treatment and vital signs taken after treatment with communications from the dialysis clinic) for each treatment for Resident #19 and failed to document the scheduled chair time on his/her care plan. The facility failed to document Resident #4's scheduled chair time on his/her care plan. The census was 127. Review of the facility's Hemodialysis (HD, the process of filtering the blood for individuals with kidney failure) Protocol policy, not dated, showed: -This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis;-Protocol:-The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This will include:-1. The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility;-2. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices, and;-3. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services;-Compliance Guidelines:-1. The facility will inform each resident before or at the time of admission, and periodically thereafter during the resident's stay, of dialysis services available;-2. The facility will coordinate and collaborate with the dialysis facility to assure that:-a. The resident's needs related to dialysis treatments are met;-b. The provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments;-c. Documentation requirements are met to assure that treatments are provided as ordered by the nephrologist (kidney doctor), attending practitioner and dialysis team, and;-d. There is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff;-3. The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes;-4. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to:-a. Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; -b. Physician/treatment orders, laboratory values, and vital signs; -c. Advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners; -d. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; -e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; -f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site; -g. Changes and/or declines in condition unrelated to dialysis; -h. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility;-5. The facility will immediately contact and communicate with the attending physician, resident/representative, and designated dialysis staff (i.e. nephrologist, registered nurse) any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan;-6. The facility will assure that arrangements are made for safe transportation to and from the dialysis facility;-7. The nurse will monitor and document the status of the resident's access site(s) upon return from		