STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265834	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quarters at Des Peres, The	13230 Manchester Road Des Peres, MO 63131

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the responsible party for one resident (Resident #4) following a change in condition, in which the resident fell out of bed, sustained an injury, and was sent to the hospital for an evaluation. The sample size was 11. The census was 123.Review of the facility's Notification of a Change in Condition Policy, revised 2/6/25, showed:Policy: The Attending Physician/Physician Extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the Resident Representative will be notified of a Change in a Resident's Condition, according to Standards of Practice and Federal and/or State Regulations. Responsibility: All Licensed Nursing Personnel, Nursing Administration, & Director of Nursing. Procedure:-Guideline for Notification of Physician/Resident Representative (not all inclusive): -Significant Change in Medical or Cognitive baseline; -Accident/Incident; -Abnormal Laboratory Results in conjunction with a change in condition; -Significant weight loss/gain as per RAI guidelines or provider specific orders; -Refusal to take Prescribed Medications; -Missing Resident. Document in the Interdisciplinary Team (IDT) Notes:-Resident Change in Condition;-Physician/Physician Extender Notification;-Notification of Resident Representative. Review of Resident #4's medical record, showed the resident's adult family (Adult Relative #2) member listed as emergency contact #1 on the face sheet. Review of the resident's medical record showed:-admission: [DATE];-Diagnoses include low blood pressure, end stage renal disease (ESRD), and endometrial cancer. Review of the resident's progress notes showed:-A progress note, dated 4/12/26 at 10:38 P.M., Resident fell out of bed and hit his/her head. Upon assessing resident, resident was complaining of left eye pain, right shoulder pain and abdominal discomfort. Blood pressure: 51/31 (Normal 120/80) Pulse :40 (Normal 60-100). Resident sent out to hospital via emergency medical technician (EMT) transport. Assistant Director of Nursing (ADON) made aware and physician.-A progress note, dated 4/13/26 at 3:01 P.M., Resident is admitted to hospital. Review of the resident's care plan, dated 4/14/26, showed:-Focus: Resident is at risk for fall. Gait/balance problems;-Goal: The resident will not sustain serious injury through the review date;-Interventions: Be sure the resident's call light is in reach and encourage the resident to use it, resident needs prompt response to all requests for assistance, follow facility fall protocol, anticipate and meet the resident's needs. During an interview on 4/13/26 at 12:10 P.M., Adult Relative 1 said he/she was not informed of the fall or the transfer to the hospital until the following day when he/she called to talk to the facility social worker. During an interview on 4/28/26 at 2:50 P.M., Adult Relative 2 said he/she was not notified of the fall or that the resident was sent to the hospital until he/she went to the facility the next day to visit the resident. The receptionist informed Adult Relative 2 that the resident was in the hospital and gave the incorrect hospital. The Adult Relative reported he/she then talked to the Administrator, who did not know which hospital. The relative said approximately 2-3 hours later, the Administrator called to report the location of the resident. Adult Resident 2 said he/she would have been expected to be notified at the time of the fall the fall occurred and the location the resident was sent. During an interview on 4/23/26 at approximately 3:15 P.M., the Administrator said he would expect staff to notify the responsible party of any change (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of condition, if they were sent out and when they returned. He would also expect documentation noted of the attempt or if they left a message. 2980936

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure services were provided in accordance with professional standards of practice by failing to document one resident's (Resident #2) insulin administration and blood glucose monitoring on the Medication Administration Record (MAR) and Treatment Administration Record (TAR). The sample size was 11. The census was 123.Review of the facility's Notification of a Change in Condition Policy, revised 2/6/25, showed:Policy: The Attending Physician/Physician Extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the Resident Representative will be notified of a Change in a Resident's Condition, according to Standards of Practice and Federal and/or State Regulations. Responsibility: All Licensed Nursing Personnel, Nursing Administration, & Director of Nursing. Procedure:-Guideline for Notification of Physician/Resident Representative (not all inclusive): -Significant Change in Medical or Cognitive baseline; -Accident/Incident; -Abnormal Laboratory Results in conjunction with a change in condition; -Significant weight loss/gain as per RAI guidelines or provider specific orders; -Refusal to take Prescribed Medications; -Missing Resident. Document in the Interdisciplinary Team (IDT) Notes:-Resident Change in Condition;-Physician/Physician Extender Notification;-Notification of Resident Representative. 1.Review of Resident #2's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/1/26, showed:-Cognitively intact;-Diagnoses included diabetes, arthritis, and respiratory failure. Review of the resident's electronic Physician Order Sheet (ePOS), showed:-An order, dated 3/9/26. Notify physician extender if blood sugar less than 70 or greater than 200;-An order, dated 3/13/26. Accuchecks three times a day (TID) with meals and bedtime and as needed (PRN) before snacks;-An order, dated 4/11/26. NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/Milliliter (ML) (Insulin). Inject eight unit subcutaneously (under the skin) before meals and at bedtime for diabetes (DM). Give eight units insulin before meals and at bedtime along with any sliding scale insulin needed;-An order, dated 4/11/26. NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin). Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 -350 = 8 units; 351 - 400 = 10 units. Any accuchecks above 400, give 15 units and recheck in four hours, subcutaneously before meals and at bedtime for DM. Review of the resident's April 2026 MAR/TAR, showed:-Accuchecks TID with meals and bed time and PRN before snacks four times a day for DM at 0800, 1200, 1700, 2100;-NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart)Inject eight unit subcutaneously before meals and at bedtime for DM. Give eight units insulin before meals and at bedtime along with any sliding scale insulin needed at 0600, 1100, 1600, and 2000;-0600 Dose showed blank on 4/12, 4/14, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, and 4/22/26;-NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart)-Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units. Any accuchecks above 400, give 15 units and recheck in four hours, subcutaneously before meals and at bedtime for DM;-0600 Dose showed blank on 4/14, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/22, and 4/23/26;-0600 blood sugar value blank on 4/14, 4/15, 4/16, 4/17, 4/19, 4/20, 4/21, 4/22, and 4/23/26. Review of the resident' s medical record, showed:-A progress note, dated 4/13/26 at 7:26 A.M. Text message sent to physician, regarding the patient's accucheck. At 0315 =15 units Novolog fast acting insulin given sliding scale (SQ). Accu check at 0720 = 598;-A progress note, dated 4/13/26 at 7:52 A.M., Physician texted back. Order for patient to have 20 units of Novolog insulin now instead of sliding scale;-A progress note, dated 4/13/26 at 8:00 A.M., Patient given 20 units Novolog insulin SQ as instructed by physician;-A progress note, dated 4/23/26 at 9:57 A.M., Physician called made aware of BS 538 and covered with scheduled sliding scale, new order received just now to 20 units of Novolog, and will be in to visit this morning in about 15 minutes, noted.-No other progress notes related to physician notification for blood sugar between 4/13/26 and 4/23/26. During an interview on 4/23/26 at 9:30 A.M., Licensed Practical Nurse (LPN) B said there (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were two nurses to take care of residents on the unit. Registered Nurse (RN) C took Resident #2's blood sugar that morning, 4/23/26. The doctor should be called if the blood sugar was greater than 400. Resident #2's blood sugar typically ran high. RN C documented the insulin. If it was not documented, then it probably was just not documented right then and there. During an interview on 4/23/26 at 9:40 A.M., LPN D said only the nurses checked the resident's blood sugar. The doctor should be notified if the result was less than 60 or greater than 300. The blood sugar reading and insulin given should be documented when it was done. Sometimes they got busy. During an interview on 4/23/26 at 9:52 A.M., RN C confirmed he/she checked Resident #2's blood sugar this morning. The other nurse, LPN B, gave the insulin to the resident. Physician E was notified by text that the resident's blood sugar was high around 8:26 A.M. to 8:45 A.M., but the physician had not gotten back to him/her yet. RN C said he/she asked the resident if the resident had anything to eat. The resident's blood sugar was always high, and he/she always wanted to change his/her sliding scale. RN C said he/she was waiting to see what Physician E wanted to do before administering any additional insulin. RN C said when the blood sugar was this high, you should call the physician instead of waiting. He/She was going to call the physician. During an interview on 4/23/26 at 10:00 A.M., Resident #2 said his/her blood sugar has not been the same since he/she arrived at the facility and they changed all his/her medications. They claim the medications were in the same family and should be the same but they were not for him/her. His/Her blood sugar was constantly up and down. He/She did not feel they were checking it as often as they should or that he/she was getting all of his/her prescribed insulin. Different nurses would administer different things. The physician did not listen, just cuts him/her off. The resident states he/she was Type One Diabetic, and that had to be managed differently than a Type two diabetic. It does not seem like they knew what they were doing. During an observation on 4/23/26 at 10:05 A.M., RN C entered the resident's room and told the resident he/she needed to recheck the resident's blood sugar. RN C said Physician E was on the way to the facility to talk to the resident and said to recheck and give 20 units if the blood sugar was high again. At 10:10 A.M., the blood sugar was 526. The resident was hesitant to take an additional amount of insulin. He/She did allow RN C to administer the 20 units of insulin. RN C said he/she was to recheck the blood sugar in an hour. During an interview on 4/23/26 at 10:20 A.M., Physician E said he/she would expect the staff to follow physician orders. He/She would also expect a phone call if the blood sugar was high and said they did call the physician that morning. Physician E said he/she would talk to the resident again but the last time the resident refused to let the physician increase the insulin dose. Physician E said it can be hard to do something when the resident refused medication changes. Physician E would expect staff to document blood sugar and insulin administered or a note if the resident refused. During an interview on 4/23/26 at 1:22 P.M., RN C said Physician E did change two of the resident's insulin medications per the resident's request. The blood sugar was checked again and was around four something. The resident seemed better, he/she was probably just frustrated. During an interview on 4/23/26 at approximately 1:45 P.M., the resident said the physician talked to him/her and again would not let the resident talk much, but was going to switch the resident back to what he/she was prescribed at the hospital prior to being admitted to the facility. During an interview on 4/23/26 at approximately 3:15 P.M., the Administrator said he would expect staff to follow physician orders and to call the physician as recommended in the order. Blank MAR/TAR could mean resident was not available. There should be a note and should be a note for refusal. For the high blood sugar of 538, the nurse should have called and should have tried again before the hour. The nurse could have also reached out to the onsite Nurse Practitioner. 2978561