STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected three of three sampled residents who expired and had money in their accounts longer than 30 days (Residents #314, #315 and #316). The census was 60. 1. Review of Resident #314's financial records, showed: -Expired on 8/19/23; -Ending balance of $390.49;	F 569		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 11/26/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	Continued From page 1 -TPL form sent on 11/1/24. 2. Review of Resident #315's financial records, showed: -Expired on 8/26/23; -Ending balance of $29.04; -TPL form sent on 11/1/24. 3. Review of Resident #316's financial records, showed: -Expired on 11/26/23; -Ending balance of $20.04; -TPL form sent on 11/1/24. 4. During an interview on 11/12/24 at 3:42 P.M., the Business Office Manager (BOM) said the facility was supposed to send the TPL form within 30 days. The BOM started working at the facility in June of last year and realized TPLs were not sent. It was not acceptable to send the funds later than 30 days.	F 569		
F 570 SS=E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a surety bond sufficient to ensure the protection of resident funds. This deficiency had the potential to affect all residents who have money in the resident trust fund. The census was 60.	F 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 570	Continued From page 2 Review of the facility's Surety Bond Invoice, dated 12/28/23, showed a bond amount of $75000. Review of the facility's average resident trust fund balance for the previous twelve months, showed: -A monthly average of $52,000.00; -For this amount, the bond amount should have been $78,000. During an interview on 11/12/24 at 2:00 P.M., the Business Office Manager said she was not aware the amount was not sufficient and would request an increase immediately. The bond amount should have been sufficient. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he was unaware the bond amount was not sufficient. The bond should be sufficient and he had the bond amount increased immediately.	F 570		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.	F 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 3 (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;	F 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 4 (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide accessible information on the location of the State Survey Agency hotline number that was readily available to residents in the facility without assistance. The census was 60. Observations throughout the survey on 11/ 7/24, 11/8/24 and 11/12/24 showed, the State Survey Agency number not posted in the facility. During a group interview on 11/8/24 at 9:55 A.M., seven residents, whom the facility identified as alert and oriented, attended the group meeting and said they did not know where the State Survey Agency hotline number was posted. During an interview on 11/12/24 at 3:17 P.M., the Director of Nursing said the State contact information was not posted. The facility has ordered a new poster and frame. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for the State Survey Agency hotline number to be posted.	F 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to assure the residents' Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) accurately reflect the residents' status for two of 26 sampled residents (Resident #57 and #60). The census was 60.

1. Review of Resident #57's significant change MDS, dated 9/17/24, showed:
-Admitted to the facility: 6/26/24;
-Diagnoses included high blood pressure, aphasia (language disorder that affects a person's ability to understand, speak, read and write), and depression;
-Special services received while a resident: Hospice Care;
-Does the resident have a condition or chronic disease that may result in life expectancy less than six months: No;
-Staff failed to accurately document the resident's condition resulted in a life expectancy of less than six months necessitating hospice services.

Review of the resident's physician order sheet, dated 11/8/24, showed an order dated 9/11/24, for Hospice care.

Review of the resident's care plan in use during the survey, showed:
-Problem: Resident has been admitted to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6	F 641		

Hospice related to diagnosis of senile degeneration of the brain;
-Goal: Resident will have his/her needs met thru the next review date;
-Interventions included: Facility and Hospice to coordinate for continuity of care. Follow up with Physician and Hospice as needed. Medication provided as prescribed. Monitor for a decline in functions. Provide spiritual and emotional support as needed.

2. Review of Resident #60's admission MDS, dated 8/6/24, showed:
-Admitted to the facility: 7/26/24.
-Diagnoses included cancer, asthma, malnutrition, and Parkinson's Disease;
-Special services received while a resident: Hospice Care;
-Does the resident have a condition or chronic disease that may result in life expectancy less than six months: No;
-Staff failed to accurately document the resident's condition resulted in a life expectancy of less than six months necessitating hospice services.

Review of the resident's physician order sheet, dated 10/13/24, showed an order dated 7/26/24, for Hospice care.

Review of the resident's medical record showed he/she expired at the facility on 10/13/24.

Review of the resident's care plan, showed:
-Problem: Resident has been admitted to Hospice related to diagnosis of metastatic lung cancer;
-Goal: Resident will have his/her needs met thru the next review date;
-Interventions included: Follow up with Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 as needed. Follow up with Physician as needed. Medication provided as prescribed. Monitor for a decline in functions. Provide medication as prescribed. 3. During an interview on 11/13/24 at approximately 2:00 P.M., the MDS Coordinator said she updates the MDS. She is responsible for the MDS. Under Section J, and answer of yes would be noted under if the person is actively dying, and there has to be a physician documentation that they are dying. If the resident is on hospice, it should be noted on the MDS under section O. 4. During an interview on 11/18/24 at 11:45 A.M., the Administrator said he would expect for the residents' MDS to be accurately coded. The MDS should be accurate and should reflect the residents' current condition.	F 641		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents who received dialysis (the clinical purification of blood as a substitute for the normal function of the kidney) had documented assessments and monitoring related to dialysis and ongoing documented communication with the dialysis center. The	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 8	F 698		

facility identified two residents who received dialysis, and one resident was sampled (Resident #53). In addition, the facility failed to have a copy of the dialysis contract. The sample was 18. The census was 60.

Review of the facility's Care of a Resident with End-Stage Renal Disease Policy, dated reviewed 10/12/24, showed:
-Policy statement: residents with end stage renal disease (ESRD, chronic irreversible kidney failure) will be cared for according to currently recognized standards of care;
-Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents;
-Education and training of staff includes, specially:
-The nature and clinical management of ESRD (including infection prevention and nutritional needs);
-The type of assessments data that is to be gathered about the resident's condition on a daily or per shift basis;
-Signs and symptoms of worsening condition and/or complications of ESRD;
-How to recognize and intervene in medical emergencies such as hemorrhage (bleeding) and septic infections (serious condition in which the body responds improperly to an infection);
-Care of the grafts (arteriovenous graft (AVG), is a surgical procedure that connects an artery and vein using a synthetic tube to create a vascular access point for hemodialysis (a medical treatment that removes waste and excess water from the blood when the kidneys can no longer do so)), and fistulas (access made by joining an artery and vein in the arm);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 9	F 698		

-Agreements between the facility and the contracted ESRD facility include all aspects of how the residents care will be managed, including:
-How the care plan will be developed and implemented;
-How information will be exchanged between the facilities.

Review of Resident #53's medical record, showed:
-Cognitively intact;
-Diagnoses included: ESRD and dependence on renal dialysis.

Review of the care plan, in use at the time of survey, showed:
-Focus: is at risk for fluid imbalance and decreased physical mobility related to diagnosis of ESRD. Dependent on dialysis Monday (M), Wednesday (W) and Friday (F);
-Goal: will remain free of complications related to diagnoses of ESRD now through next review;
-Interventions: ensure to attend dialysis appointments as scheduled, monitor for infections and monitor shunt site (a surgically created connection between an artery and vein) for bruit and thrill (sound and sensation that indicate a good blood flow in a dialysis fistula or graft).

Review of the order summary, dated active orders as of 11/6/24, showed an order to check every shift for monitoring dialysis access. Report absence or weak thrill or bruit to dialysis provider and primary medical doctor, start date 8/29/24.

Review of the Medication Administration Record (MAR)/Treatment Administration Record (TAR) dated 10/1/24 through 10/31/24. showed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 10	F 698		

documentation to show staff checked every shift for monitoring dialysis access or report the absence or weak thrill or bruit to the dialysis provider and primary medical doctor.

Review of the progress notes dated 10/1/24 through 10/31/24, showed:
-On 10/9/24 at 1:14 P.M., 10/18/24 at 7:55 A.M., 10/21/24 at 1:35 P.M., and on 10/30/24 at 6:42 P.M., staff documented dialysis assessments;
-Staff did not document any other dialysis assessments.

Review of the Dialysis Communication Records, provided by the facility, dated 10/1/24 through 10/31/24, showed four out of 13 assessments were completed.

Review of the MAR/TAR, dated 11/1/24 through 11/6/24, showed no documentation to show staff checked every shift for monitoring dialysis access or report the absence or weak thrill or bruit to the dialysis provider and primary medical doctor.

Review of the progress notes, dated 11/1/24 through 11/6/24, showed staff did not document any dialysis assessments.

Review of the dialysis communication records, provided by the facility, showed no assessments were completed from 11/1/24 through 11/6/24.

During an interview on 11/12/24 at 11:40 A.M., Licensed Practical Nurse (LPN) A said residents who received dialysis services had their vital signs and weights completed before going to dialysis. This information was documented on the dialysis communication form along with the medications given to the resident. The form was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 11	F 698		

sent with the resident to dialysis. He/She also called dialysis to give them a report and he/she would document that the resident went out to dialysis in the electronic medical record. When the resident returned home, the nurse should reassess the resident by taking their resident's vital signs and checking the access site. The only place the weight and vital signs are documented was on the dialysis communication form.

During an interview on 11/12/24 at 12:43 P.M., LPN E said residents who received dialysis services had a communication form that was completed when they went to dialysis which included the resident's vital signs, the location of the dialysis access site and the medications the resident received. The form was sent to dialysis with the resident. Dialysis was pretty good at sending the forms back to the facility.

During an interview on 11/13/24 at 8:15 A.M. and 11:35 A.M., the Director of Nursing (DON) said the facility did not have a copy of the dialysis contract. The facility reached out to the dialysis company to try to obtain a copy but was told the contract was at a different location. She would expect the facility to have a copy of the dialysis contract. Staff should check the resident's vital signs and weight before going to dialysis and document them on the communication form. The form is sent to dialysis with the residents. Sometimes the facility got the form back and sometimes dialysis did not send the form back. If the resident returned home and there was no weight or vitals completed by dialysis, the nurse should complete it. The nurse should monitor the access site for bleeding, bruit and thrill every shift and document it on the TAR. The DON would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 12 expect for dialysis monitoring to be documented. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for dialysis monitoring to be documented. During an interview on 11/13/24 at 8:15 A.M. and 11:35 A.M., the DON said the facility did not have a copy of the dialysis contract. The facility reached out to the dialysis company to try to obtain a copy but was told the contract was at a different location. She would expect the facility to have a copy of the dialysis contract During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for the facility to have a copy of the dialysis contract on premises	F 698		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 37 opportunities observed, three errors occurred resulting in an 8.11% error rate (Resident #50). The census was 60. Review of the facility's Medication Administration Policy, undated, showed: -Only licensed personnel or certified medical	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 13	F 759		

technicians (CMT) are assigned responsibility of preparing, administering, and recording medication or permitted access to drug storage areas;
-Medication may be administered to a resident only if ordered by a practitioner licensed to prescribe medication in that location.

Review of the facility's Administering Medications through a Metered Dose Inhaler Policy, dated reviewed 10/1/24, showed:
-Purpose: The purpose of this procedure is to provide guidelines for the safe administration of inhaled medications;
-Allow at least one minute between inhalations of the same medication and at least two minutes between inhalations of different medications.

1. Review of Resident #50's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 7/2/24, showed:
-Cognitively intact;
-Diagnoses included: high blood pressure and chronic obstructive pulmonary disease (COPD, chronic lung disease).

Review of the resident's Order Summary Report, active orders as of 11/8/24, showed:
-An order for: Spironolactone (used to treat fluid retention) 25 milligram (mg), give one tablet once time daily for diuretic (water pill);
-An order for: Spiriva Respimat (used to treat COPD) Inhalation (Inhaler) 1.25 microgram (mcg), give two puff inhale one time daily for COPD;
-An order for: Combivent Respimat (Ipratropium-Albuterol, medication used to treat lung disease) inhalation 20-100 mcg, give two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 14	F 759		

puff inhale one time daily for COPD.

Observation on 11/8/24 at 9:10 A.M., showed CMT D administered one tablet of Spironolactone- Hydrochlorothiazide (a combination of two different diuretic medications) 25-25, then administered Combivent Respimat inhaler one puff and Spiriva Respimat inhaler one puff, without waiting at least 2 minutes between the different types of inhalers. At 9:40 A.M., CMT D administered Spiriva Respimat inhaler one puff and Combivent inhaler one puff without waiting at least 2 minutes between the different types of inhalers.

During an interview on 11/8/24 at 11:20 A.M., the pharmacist said Spironolactone and Spironolactone HCTZ were not the same medication, and the medications are not interchangeable.

During an interview on 11/8/24 at 11:39 A.M., the Director of Nursing (DON) said when staff administer medication, she would expect for staff to follow the five rights of medication administration (right resident, right medication, right dose, right time, and right route). Spironolactone and Spironolactone HCTZ were not the same medication. If the card of medication did not match the Medication Administration Record (MAR) she would expect for CMTs to notify the nurse and the nurse to verify the order. She would expect for staff to administered one inhaler, both two puffs, then wait a few minutes and administer the second inhaler, two puffs.

During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect staff to follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 15 physician orders and to follow the facility's policies and procedures.	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label, date, and cover food in the kitchen. In addition, the facility failed to ensure that kitchen equipment was clean and was in proper working order. These deficient practices had the potential to affect all residents who consumed food from the facility kitchen. The census was 60. 1. Observations of the kitchen dry storage room, showed: -On 11/6/24 at 11:14 A.M., 11/7/24 at 4:14 P.M., and 11/8/24 at 2:46 P.M.,:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 16	F 812		

-A package of opened mostaccioli noodles wrapped in plastic without a date;
-A package of opened cheese flakes wrapped in plastic without a date;
-On 11/6/24 at 11:14 A.M. and 11/7/24 at 4:14 P.M., a package of opened stuffing mix wrapped in plastic without a date.

2. Observation on 11/6/24 at 11:14 A.M. and 11/7/24 at 4:14 P.M., showed:
-Walk in cooler:
-Tortilla shells opened, wrapped in plastic, and without a date;
-A salad mix opened, wrapped in plastic, and without a date;
-Walk in freezer:
-A box of cookies opened, undated, and exposed to the air;
-Catch all freezer:
-French toast in a plastic bag with a knot tied at end, without a date;
-Biscuits in a plastic bag with a knot tied at end, with a hole in the bag, opened, and exposed to air;
-A package of hot dogs opened, wrapped in plastic, and without a date;
-An unidentified food item in an aluminum container, wrapped in plastic, and without a date.

3. Observations on 11/6/24 at 11:14 A.M., 11/7/24 at 4:14 P.M., and 11/8/24 at 2:46 P.M. in the kitchen, showed:
-The deep fryer:
-Old grease sat in the fryer;
-Caked on grease and batter along the inside of the fryer;
-Two straining baskets with caked on grease;
-The stove:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 -Heavy caked on stains on the stove burners; -Old food particles inside the stove burners. 4. Observations of the walk-in cooler on 11/6/24 at 11:14 A.M., 11/7/24 at 4:14 P.M., and 11/8/24 at 2:46 P.M., showed a fan in the ceiling leaked water into a metal pan that sat on the top shelf in the cooler. 5. During interviews on 11/13/24 at 2:23 P.M., the Director of Dietary Services said it is her expectation that all food items should be properly labeled, dated, and stored. Everyone is responsible for labeling and dating food. She does not have a designated sanitation staff person. Staff clean every day in the kitchen, but deep cleaning is done on Sundays because their stock comes in on Mondays. She does not fry a lot in the deep fryer. She changes the grease one time a week. She had not used the deep fryer since last week on Thursday. She is responsible for cleaning the stove. The stove should be getting cleaned every two weeks. Regarding the fan in the cooler, they have someone coming out to look at it on Monday. She expects for the fan as well as all the equipment in the kitchen to be in proper working order. Maintenance is aware of the issue and have called someone out to fix it. 6. During interviews 11/13/24 2:35 P.M. and 11/18/24 at 11:45 A.M., the Administrator said he would have expected for all food to be properly labeled, dated, and stored. He also expected for all equipment in the kitchen to be clean and in proper working order.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18	F 880		

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to place signage and follow indications for enhanced barrier precautions (EBP, an infection control intervention that utilizes personal protective equipment (PPE) to reduce the spread of multidrug-resistant organisms (MDROs)) for two residents who had pressure ulcers (open wounds that occur when skin and tissue are damaged by prolonged pressure), and an indwelling urinary catheter (a flexible tube that drains urine from the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

bladder into a collection bag) (Residents #42 and #38). In addition, the facility failed to ensure the indwelling urinary catheter bag was off the floor for one resident (Resident #38). Furthermore, the facility failed to ensure the nebulizer mask was stored in bag or clean container when not in use for one resident (Resident #45). The sample was 18. The census was 60.

Review of the Centers for Disease Control and Prevention's (CDCs) Implementation of PPE Use in Nursing Homes to Prevent Spread of MDRO guidelines, dated 4/2/2024, showed:
-Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization;
-Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:
-Dressing;
-Bathing/showering;
-Transferring;
-Providing hygiene;
-Changing linens;
-Changing briefs or assisting with toileting;
-Device care or use: central line, urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

catheter, feeding tube, tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe (trachea) to help a person breathe)/ventilator (type of breathing aparatus);

-Wound care: any skin opening requiring a dressing;

-In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions (Steps taken to prevent the spread of germs), they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk;

-When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this:

-Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE (such as, gown and gloves);

-Signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves;

-Make PPE, including gowns and gloves, available immediately outside of the resident room;

-Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room);

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

-Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room;
-Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education;
-Provide education to residents and visitors.

Review of the facility's Enhanced Barrier Precautions Policy, revised on 10/12/24, showed:
-Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms;
-Prompt recognition of need:
-All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions;
-All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions;
-The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities;
-Initiation of Enhanced Barrier Precautions:
-The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC;
-Enhanced barrier precautions will be initiated for residents with any of the following:
-Wounds (such as, chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

ulcers) and/or indwelling/implanted medical devices (such as, central lines, ports, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO;
-Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply.

The facility did not have policies to address process and procedure for infection control related to oxygen tubing and nebulizer mask storage.

1. Review of Resident #42's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/21/24, showed:
-Both short term and long-term memory loss;
-Resident had an indwelling catheter;
-Two Stage III pressure ulcers (full thickness tissue loss, subcutaneous fat may be visible, but the bone, tendon or muscle is not exposed) Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling);
-Two Stage IV pressure ulcers (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling);
-One Unstageable (slough and/or eschar known but not stageable due to coverage of wound bed by slough and/or eschar);
-One unstageable (deep tissue suspected deep tissue injury in evolution);
-Diagnoses included: cancer, heart failure, benign prostatic hyperplasia (BPH, enlarged prostate), stroke and aphasia (a language disorder that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		

makes it difficult to communicate due to damage to the brain's language center).

Observation on 11/8/24 at 7:40 A.M., showed no sign on the door to indicate the resident was on EBP. The resident sat in his/her chair with the covered catheter drainage tube draining to gravity. Certified Nurse Aide (CNA) C and Certified Medication Technician (CMT) D entered the resident's room, performed hand hygiene and put on gloves. CNA C and CMT D transferred the resident from the chair to the bed using a mechanical lift. After the resident was in bed, CNA C and CMT D rolled the resident side to side to remove his/her pants and brief. The resident had a dressing on his/her left buttocks dated 11/5/24. The CMT provided personal hygiene to the resident while CNA C held the resident over on his/her side. There were two superficial open areas on the sacrococcygeal area (pertaining to both the sacrum and coccyx (the tailbone)) which were not covered. After the CMT finished cleaning the resident, he/she applied a barrier cream to the buttocks and removed his/her gloves and left the room. A few minutes later, CMT D and the Assistant Director of Nursing (ADON) entered the room, performed hand hygiene and put gloves on. The ADON observed the open areas on the sacrococcygeal area, removed her gloves and left the room to go get supplies to clean the wounds. CMT D emptied 600 milliliters (mL) from the resident's catheter. The ADON returned to the room, performed hand hygiene, put gloves on, then provided wound care to the resident. Staff failed to wear a gown while providing high-contact resident care.

2. Review of Resident #38's quarterly MDS, dated 10/18/24, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25	F 880		

-Cognitively intact;
-Diagnoses included traumatic spinal cord dysfunction (a condition where the spinal cord is damaged due to trauma), hypotension (low blood pressure), and quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down);
-Resident had indwelling catheter;
-One Stage II pressure ulcer;
-One Stage III pressure ulcer;
-One Stage IV pressure ulcer.

Observation on 11/8/24 at 10:28 A.M., showed no EBP sign on the door. The resident's indwelling catheter bag did not have a barrier cover on it and hung on the side of the lowered bed. Part of the bag lay on the floor. CNA C entered the room, performed hand hygiene and applied gloves. CNA C did not adjust or pick up the catheter bag. At approximately 10:35 A.M., the ADON entered the room, performed hand hygiene and applied gloves. The ADON provided wound care while CNA C assisted in turning the resident from side to side. Both staff failed to wear a gown while providing high-contact resident care.

During an interview on 11/8/24 at 11:39 A.M., the Director of Nursing (DON) and ADON said they had not heard of EBP, and they did not recall hearing about it.

3. During an interview on 11/13/24 at 2:40 P.M., the Administrator said he would expect for staff to use EBP. He would expect the staff to keep the indwelling urinary catheter bag off the floor.

4. Review of Resident #45's quarterly MDS, dated 9/16/24, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26	F 880		

-Admitted to the facility: 10/20/23;
-Understood/understand;
-Severely impaired vision;
-Special treatments and programs; Oxygen therapy: while a resident;
-Diagnoses included COPD (Chronic obstructive pulmonary disease, is a common lung disease that makes it difficult to breathe), diabetes mellitus, and hyperlipidemia (high cholesterol).

Review of the resident's care plan, used during the survey showed:
-Focus: The resident requires oxygen therapy related to diagnosis of persistent asthma and is frequently short of breath (SOB);
-Goal: The resident will remain free of SOB and complications related to diagnosis of persistent asthma;
-Interventions: Keep head of bed (HOB) elevated for optimal breathing. Medication provided as prescribed. Monitor oxygen saturation (SPO2, percentage of oxygen in blood) as ordered. Provide supplemental oxygen as prescribed.

Review of the resident's physician's order sheet dated 11/8/24 showed:
-An order dated: 10/18/24, for albuterol sulfate inhale aero 108 micrograms (mcg)/ACT (90 MCG base equivalent) two puff inhale orally every six hours as needed for SOB/wheezing. Unsupervised. Self-administration may keep at bedside;
-An order dated: 9/9/24, albuterol sulfate nebulization solution (2.5 mg/3 ML) 0.083% three milliliter (ml) inhale orally via nebulizer every six hours as needed for SOB;
-An order dated: 5/27/24, start date: 6/3/24, for fluticasone-salmeterol aerosol powder breath activated 250-50 mcg/Dose 1 puff inhale orally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265392	A. BUILDING _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	**5460 DELMAR BLVD SAINT LOUIS, MO 63112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27 two times a day for lung disease. Observations of the resident, showed: -On 11/07/24 at 10:33 A.M., a nebulizer machine (turns liquid medicine into a mist that can be inhaled to treat lung conditions) and the mask lay uncovered on the windowsill; -On 11/08/24 at 11:15 A.M., a nebulizer mask lay on the windowsill. No bag to cover the mask was noted; -On 11/08/24 at 2:36 P.M., the resident was out of his/her room. The nebulizer mask lay on the windowsill and was uncovered; -On 11/12/24 at 12:03 P.M., the resident sat in his/her room. The nebulizer mask lay on the windowsill, uncovered. During an interview on 11/13/24 at 2:35 P.M., the administrator said he would have expected for the resident's mask to have been covered due to infection control issues.	F 880		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02089	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II See deficiency cited at F759.	A4055		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II See deficiency cited at F698.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by:	A4086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02089	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4086	Continued From page 1 Class II See deficiency cited at F880.	A4086		
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS At all times, including while being stored, prepared, displayed, served or transported to or from the facility, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage and overhead leakage or overhead drippage from condensation. The temperature of potentially hazardous food shall be forty-five degrees Fahrenheit (45°F) or below or one hundred forty degrees Fahrenheit (140°F) or above at all times, except as otherwise provided in this section. In the event of a fire, flood, power outage or similar event that might result in the contamination of food, or that might prevent potentially hazardous food from being held at required temperatures, the person in charge shall immediately contact the Department of Health and Senior Services (the department). Upon receiving notice of this occurrence, the department shall take whatever action that it deems necessary to protect the residents. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F812.	A7015		
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning Surfaces of equipment not intended for contact	A7056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02089	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A7056	Continued From page 2 with food, but which are exposed to splash or food debris or which otherwise require frequent cleaning, shall be designed and fabricated to be smooth, washable, free of unnecessary ledges, projections or crevices, and readily accessible for cleaning, and shall be of such material and in a repair as to be easily maintained in a clean and sanitary condition. III This regulation is not met as evidenced by: See deficiency cited at F812.	A7056		
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitized Where equipment and utensils are used for the preparation of potentially hazardous foods on a continuous or production-line basis, utensils and the food-contact surfaces of equipment shall be washed, rinsed and sanitized at intervals throughout the day on a schedule based on food temperature, type of food and amount of food particle accumulation. III This regulation is not met as evidenced by: See deficiency cited at F812.	A7065		
A8007	19 CSR 30-88.010(7) Res Rights/Rules Posted, Alz Unit Info Information regarding resident rights and facility rules shall be posted in a conspicuous location in the facility and copies shall be provided to anyone requesting this information. Informational documents which contain, but are not limited to, updated information on selecting an Alzheimer's special care unit or program shall be given by a facility offering to provide or providing these services to any person seeking information about	A8007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02089	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8007	Continued From page 3 or placement in an Alzheimer's special care unit or program. III This regulation is not met as evidenced by: See deficiency cited at F574.	A8007		
A9013	19 CSR 30-88.020(11)(B) Deceased Resident Fund Use Requirements Upon the death of a resident, the operator shall contact the Department of Social Services (DSS), MO HealthNet Division, Third Party Liability Unit, to determine if the deceased resident is a MO HealthNet participant or has been a recipient of aid, assistance, care, services, or if the resident has had moneys expended on his/her behalf by DSS. The facility shall document the contact(s) with and response(s) from DSS. II/III (B) None of the resident ' s personal funds shall be paid to an operator, fiduciary, guardian and conservator, conservator, or other person until the operator has fully complied with section 198.090.1., RSMo, except that funeral expenses may be paid from a resident ' s personal funds held by a facility if no other funds are available to cover the cost. If funds are used for this purpose, this fact and the amount used shall be noted on the account report submitted to DSS and documentation of payment shall be attached. II/III This regulation is not met as evidenced by: Class III See deficiency cited at F569.	A9013		
A9023	19 CSR 30-88.020(14) Resident Fund Bond Requirements	A9023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02089	A. BUILDING: _____ B. WING _____	C 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELHAVEN MANOR	5460 DELMAR BLVD SAINT LOUIS, MO 63112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A9023	Continued From page 4 The bond required by section 198.096, RSMo, for operators holding personal funds of residents shall be in a form approved by the department and shall provide that residents who allege that they have been wrongfully deprived of moneys held in trust may bring an action for recovery directly against the surety. The bond shall be in an amount equal to at least one and one-half (1 1/2) times the average monthly balance of the residents ' personal funds, including residents ' petty cash, or the average total of the monthly balances for the preceding twelve (12) months. The average monthly balance(s) or the average total of the monthly balance(s) shall be rounded to the nearest one thousand dollars ($1,000). One (1) bond may be used to cover the residents ' funds in more than one (1) facility operated by the same operator, if the facility is a multilicensed facility on the same premises. If not on the same premises, then one (1) bond may be used if the bond specifies the amount of coverage provided for each individual facility and the coverage for each facility is a minimum of one thousand dollars ($1,000). II/III This regulation is not met as evidenced by: Class III See deficiency cited at F570.	A9023		

FEDERAL PLAN OF CORRECTION

Agency Name	Delhaven Manor
STREET ADDRESS, CITY, ZIP:	5460 Delmar Blvd St. Louis, MO 63112
Provider Number	265392
Exit Date	11/13/2024

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERRENCED TO THE APPROPRIATE DEFICIENCY)		
Tag Number	**The Administrator signing and dating the first page of the CMS-2567 is indicating their approval of the plan of correction being submitted on this form.**	**(X5) COMPLETION DATE**
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Delhaven Manor agrees with the allegations and citations listed on the statement of deficiencies. Delhaven Manor maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Delhaven Manor written credible allegation of compliance. By submitting this plan of correction, Delhaven Manor does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Delhaven Manor reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F569	In Response to F569, the facility upon discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's refunds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** All discharged residents accounts were audited and corrected if over 30 days. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	12/25/2024
F569	CFR(s): 483.10(f)(10)(iv)(v) In response to findings of review of residents #314, #315, and #316. The Administrator will conduct an in-service education for all the leadership team on all resident's funds must be returned to any resident leaving the facility within 30 days of discharge. This will be completed by 12/25/2024.	12/25/2024

F569	CFR(s): 483.10(f)(10)(iv)(v) In response to findings of review of residents #314, #315, and #316. The Account Manager will audit all discharged residents weekly to ensure all funds have been returned to the resident. The name of resident, date of discharge, amount in account at discharge, and date returned will be kept on an audit spreadsheet. This will be completed by 12/25/2024.	12/25/2024
F569	CFR(s): 483.10(f)(10)(iv)(v) In response to findings of review of residents #314, #315, and #316. The Accounting and Records Of Resident Funds policy will be reviewed by the Administrator and Account Manager. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024
F570	In Response to F570, the facility must purchase a surety bond or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** A call was place to corporate office and bond was increase that day. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	12/25/2024
F570	CFR(s): 483.10(f)(10)(vi) In response to the findings. The administrator will conduct an in-service for all leadership team on Surety Bond policy addressing facility's surety bond. This will be completed by 12/25/2024.	12/25/2024
F570	CFR(s): 483.10(f)(10)(vi) In response to findings. The Account Manager will complete a weekly audit of surety bond amount to ensure the proper amount is in place. This will be documented on audit spreadsheet. This will be completed by 12/25/2024.	12/25/2024
F570	CFR(s): 483.10(f)(10)(vi) In response to findings. The Surety Bond policy will be reviewed by the Administrator and Account Manager. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024

F574	In Response to F574, the facility recognizes the residents has the rights to receive notices orally and in writing a copy of legal rights. A list of names and addresses and telephone numbers of all pertinent State regulatory and informational agencies. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** Resident Rights and Hotline numbers were posted on each floor. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	
F574	CFR(s): 483.10(g)(4)(i)-(vi) In response to the findings. The Resident Rights policy will be reviewed by the Administrator and Director of Nursing. This will be completed by 12/25/2024.	12/25/2024
F574	CFR(s): 483.10(g)(4)(i)-(vi) In response to findings. The resident right and hotline posters were place on each floor in a visible area for the residents and visitors to read This will be completed by 12/25/2024.	12/25/2024
F574	CFR(s): 483.10(g)(4)(i)-(vi) In response to findings. The Administrator will perform a weekly audit to ensure all information is posted throughout the facility, including on each floor. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024
F641	In Response to F641, the facility recognizes that all resident assessments must accurately reflect the resident's status. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** All residents care plans were audited for accuracy and updated if needed. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice.	12/25/2024

	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	
F641	CFR(s): 483.20(g) In response to the findings with Resident #57 and #60. The Resident Assessments policy will be reviewed by the Administrator, Director of Nursing and MDS Director. This will be completed by 12/25/2024.	12/25/2024
F641	CFR(s): 483.20(g) In response to findings with Resident #57 and #60. The MDS Coordinator will do an immediate audit of all residents for a change in condition. The MDS Coordinator will complete a weekly audit of care plans for any change in conditions and update assessment at that time. This will be completed by 12/25/2024.	12/25/2024
F641	CFR(s): 483.20(g) In response to findings with residents #57 and #60. The Director of Nursing or designee will discuss any significant changes in a resident's condition during the AM Quality meeting and the MDS Coordinator will update care plan at that time. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024
F698	In Response to F698, the facility recognizes it must ensure that residents who require dialysis receive such services, consistent with professional standards of practice. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** Call placed to receive contract from dialysis company. In-services to begin on care of end stage renal residents. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents with end stage renal disease have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	12/25/2024
F698	CFR(s): 483.25(l) In response to the findings with Resident #53. The End Stage Renal Disease, Care of a Resident with policy will be reviewed by the Administrator and Director of Nursing. This will be completed by 12/25/2024.	12/25/2024
F698	CFR(s): 483.25(l) In response to findings with Resident #53. The Administrator will get a copy of the dialysis contract and keep it at facility. This will be completed by 12/25/2024.	12/25/2024

F698	CFR(s): 483.25(l) In response to findings to Resident #53. The Director of Nursing or designee will conduct an in-service for all Nurses on the care of a resident with end stage renal disease. This will include assessments, signs, and symptoms of decline, managing medical emergencies, care of grafts and fistulas and communication. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024
F759	In Response to F759, the facility recognizes that medication error rates are not to be above 5 percent. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** In-service on medication administration was started. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	12/25/2024
F759	CFR(s): 483.45(f)(1) In response to the findings with Resident #50. The Medication Administration policy will be reviewed by the Administrator and Director of Nursing. This will be completed by 12/25/2024.	12/25/2024
F759	CFR(s): 483.45(f)(1) In response to findings with Resident #50. The Director of Nursing or designee will conduct an in-service on medication administration, including inhaler use to all Nurses and CMTs. Medication 5-Rights will be part of the in-service. This will be completed by 12/25/2024.	12/25/2024
F759	CFR(s): 483.10(g)(4)(i)-(vi) In response to findings with Resident #50. The Director of Nursing or designee will audit 10 charts a week for correct matching of physician orders and MAR. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	

F812	In Response to F812, the facility recognizes that it must store, prepare, distribute, and serve food in accordance with professional standards for food service safety. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** All food was dated and stored properly. A work order was placed to fix leaking cooler within the hour of finding. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	12/25/2024
F812	CFR(s): 483.60(i)(1)(2) In response to the findings. The Food preparation and Service policy will be reviewed by the Administrator and Dietary Manager. This will be completed by 12/25/2024.	12/25/2024
F812	CFR(s): 483.60(i)(1)(2) In response to findings. The Dietary Manager or designee will conduct an audit weekly ensuring that all food is covered, labeled, and safely stored. This will be completed by 12/25/2024.	12/25/2024
F812	CFR(s): 483.60(i)(1)(2) In response to findings. The Dietary Manager will schedule a weekly deep clean of the kitchen, including fryer, stove and walk-in coolers. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024
F880	In Response to F880, the facility will conduct an annual review of its Infection Prevention and Control Program and update the program as necessary. **What Corrective action(s) will be accomplished for those residents found to have affected by the alleged deficient practice;** Enhanced Precaution Barrier signs were place on appropriate resident doors immediately. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All Residents have the potential to be affected by the alleged deficient practice.	12/25/2024

	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	
F880	CFR(s): 483.80(a)(1)(2)(4)(e)(f) In response to the findings with Residents #42, #38, and #45. The Infection Prevention and Control Committee policy will be reviewed by the Administrator and Director of Nursing. This will be completed by 12/25/2024.	12/25/2024
F880	CFR(s): 483.80(a)(1)(2)(4)(e)(f) In response to findings with Residents #42, #38, and #45. The Director of Nursing or designee will conduct an in-service for all nursing staff on enhanced barrier precautions and infection control practices. This will be completed by 12/25/2024.	12/25/2024
F880	CFR(s): 483.10(g)(4)(i)-(vi) In response to findings With Residents #42, #38, and #45. The Director of Nursing will perform an Infection Control audit on each floor weekly. Any issues will be addressed immediately. This will be completed by 12/25/2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i. e what quality assurance program will be put into place.** The weekly audit will be discussed in Am Quality meeting each morning.	12/25/2024
A4055	19 CSR30-85.042(46) Safe/Effective Medication System Please see response to F759.	12/25/2024
A4075	19 CSR 30.85.042(66) Nursing Care per Res Condition Please see response to F698.	12/25/2024
A4086	19 CSR 30.85.042(77) Infection Control/Communicable Disease Please see response to F820	12/25/2024
A7015	19 CSR 30-87.030(13) Food-Protected, Temp, Need to Contact DHSS Please see response to F812	12/25/2024
A7056	19 CSR 30-87.030(54) Nonfood Contact Surfaces, Cleaning Please see response to F812	12/25/2024
A7065	19 CSR 30-87.030(63) Food-Contact Surfaces Washed/Rinsed/Sanitized Please see response to F812	12/25/2024
A8007	19 CSR 30.88.010(7) Res Rights/Rules Posted, Alz Unit Info Please see response to F574	12/25/2024
A9013	19 CSR 30-88.020(11)(B) Deceased Resident Fund Use Requirements Please see response to F569	12/25/2024
A9023	19 CSR 30-88.0200(14) Resident Fund Bond Requirements Please see response to F570	12/25/2024