

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER St Peters Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Spencer Road Saint Peters, MO 63376	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1) in a review of 11 sampled residents, remained free from physical abuse when on Certified Nurse Aide (CNA) B aggressively moved the resident in bed, causing the resident to yell out for help, and report CNA B was too rough and hurt him/her. The resident was tearful, upset and said he/she did not want CNA B to come back after the incident. The resident sustained bruising to the right arm as identified on the facility skin assessment dated [DATE]. During an interview on 9/4/25, the resident said he/she was scared of CNA B. The facility census was 78. On 9/10/25 at 2:54 P.M. the administrator was notified of the past noncompliance which occurred on 8/25/25. On 8/25/25 CNA B physically abused Resident #1 while providing his/her care in an aggressive manner. Licensed Practical Nurse (LPN) A stopped the care and asked CNA B to leave the facility. CNA B was terminated. The administrator and regional nurse provided education to staff members on abuse and neglect. The deficiency was corrected on 8/26/25. Review of the facility's Abuse Prevention and Prohibition Program policy, updated 10/24/22, showed the following: -Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property; -The facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse; -Resident assessments and care planning are performed to monitor resident needs and address behaviors that may lead to conflict; -The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect including: -Physical Abuse; a. Welts or bruises; -Possible signs and symptoms of psychological abuse or neglect; b. Paranoia; c. Inconsistent explanations for injuries; d. Anger. 1. Review of Resident #1's undated, face sheet showed the following: -The resident readmitted to the facility on [DATE]; -He/She was his/her own responsible party; -Diagnoses included flaccid hemiplegia affecting left nondominant side (type of one-sided paralysis where the left side of the body is completely limp and lacks muscle tone, usually due to a brain or spinal cord injury), thrombocytopenia (blood has a lower-than-normal number of platelets), contracture (permanent shortening or tightening of muscles, tendons, or other soft tissues that limits the range of motion at a joint) of the left lower extremity, generalized anxiety disorder (chronic mental health condition characterized by excessive, persistent, and unreasonable worry or anxiety about various aspects of life), and Alzheimer's disease (progressive brain disorder that causes memory loss, confusion, and other cognitive decline). Review of the resident's care plan, dated 5/22/24, showed the following: -He/She had an activity of daily living (ADL) self-care performance deficit related to hemiplegia and generalized weakness; -He/She required maximal assist of one staff to turn and reposition in bed; -He/She was dependent on two staff for toileting; -The resident had impaired cognitive function due to diagnosis of Alzheimer's disease; -Cue, reorient and supervise as needed; -He/She had bowel incontinence; -Provide peri care after each incontinent episode; -The resident had an alteration in hematological status related to thrombosis (clot); -He/She may bruise easily. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/14/25, showed the following: -The resident had moderately impaired cognition; -He/She had functional limitations in range of motion with bilateral upper and lower extremities; -He/She was dependent on staff on toileting hygiene; -He/She required maximal assistance of staff with bed mobility; -He/She was always incontinent of bladder and bowel. Review of the resident's weekly skin observation, dated 8/21/25, showed the resident had bruising to the back of his/her left hand. There were no other areas of concern or bruising identified. Review of the resident's weekly skin observation, dated 8/26/25, showed the resident had a bruise to his/her right arm. Review of a statement sent by Licensed Practical Nurse (LPN) A to the administrator on 8/25/25 at 7:24 A.M., showed the following: -He/She observed that the resident's eyes were teary, and the resident yelled, help me and make him/her stop hurting me. CNA B came in and woke me up out of my sleep, scared me half to death, and was being rough with me; -LPN A tried to provide the resident comfort, then observed CNA B attempting to leave the resident soiled, with his/her incontinence brief completely off, while covering him/her with only a sheet; -When he/she said he/she was going to assist, put on gloves and approached the resident, CNA B suddenly grabbed the resident and forcefully turned him/her to his/her side, nearly causing the resident to fall out of bed. CNA B then began aggressively pulling linens and soiled pads from underneath the resident, which caused feces to spread throughout the room; -Recognizing how aggressive the aide was acting, he/she told CNA B to stop</p>		