STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265589	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Rehab and Healthcare Center	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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff consistently provided assistance with showering/bathing and personal hygiene to five residents (Residents #3, #90, #88, #2, and #37), who required assistance with showers/bathing, in a review of 23 sampled residents. The facility census was 83. Review of the facility policy, Care and Services, revised 10/24/22, showed the following:-To ensure through an interdisciplinary team (IDT) process, that all residents receive the necessary care and services based on an individualized comprehensive assessment process;-Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of a long-term care facility;-Care and services are provided in a manner that consistently enhances self-esteem and self-worth;-Once admitted , the resident receives an admission assessment where initial care and service needs are identified.-The IDT receives and reviews initial assessment information to ensure that members of the IDT interact with residents in a manner that enhances self-esteem and self-worth, such as activities related to bathing, grooming;-The IDT facilitates opportunities for residents to exercise choice and self-determination during activities of daily living (ADLs).-The IDT provides care and services to residents with reasonable accommodations of each resident's individual needs and preferences. Review of the facility policy, Shaving, revised 10/24/22, showed the following:-To increase cleanliness and improve the resident's self-image.-The Facility provides for the removal of facial hair as a component of the resident's hygienic program.-Male residents may be shaved daily and female residents may be shaved as needed. The facility did not provide a policy specific to showers and Activities of Daily Living (ADL) needs. 1. Review of Resident #3's care plan, revised 02/27/26, showed the following:-He/She was totally dependent on staff for showering/bathing;-Staff to check nail length and trim and clean on bath day and as necessary. Review of the resident's quarterly Minimum Data Set (MDS), dated [DATE], showed the following:-He/She had severely impaired cognition;-He/She was totally dependent on staff for all activities of daily living including showering/bathing and personal hygiene. Observation on 06/08/26 at 2:25 P.M. showed the following:-The resident's hair was in knots and in a messy bun on top of his/her head;-The resident had white flakes in his/her hair; -The resident scratched at dug at his/her scalp. During an interview on 06/07/26 at 4:55 P.M. and 06/08/26 at 2:25 P.M., the resident's family member said the following:-Staff were not giving the resident his/her showers; -He/She had to ask staff a couple of weeks ago to give the resident a shower because the resident's skin was so dry and flaky. The resident was so itchy and scratching at his/her skin since it had been so long since he/she had a shower/bath;-He/She told staff a couple of weeks ago he/she would like the resident to receive a bath/shower every other day;-The resident only had one bath/shower in the last couple of weeks;-He/She had to clean and trim the resident's nails yesterday because they were so long and dirty and staff were not doing it;-The resident needed his/her hair washed. 2. Review of Resident #90's admission assessment, dated 02/11/26, showed the resident was cognitively intact and required partial/moderate assistance for bathing. Review of the resident's Care Plan, revised 02/20/26, showed the resident required assistance to shower/bathe. Review of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's Shower Sheets, dated May 2026, showed the resident did not get a shower between 04/30/26 and 05/5/26 (five days); 05/07/26 and 05/12/26 (five days) 05/14/26 and 05/18/26 (four days); and 05/21/26 and 05/27/26 (six days). Observation 06/07/26 at 1:15 P.M., showed the resident's hair was disheveled and greasy. During interview on 06/07/26 at 1:15 P.M., the resident said did not get his/her showers twice a week very often. Staff told him/her they looked at the schedule wrong and missed his/her shower. The staff did not make up his/her shower when he/she missed his/her showers. There were times when he/she went all week without a shower, but staff say his/her showers were documented. It was frustrating and he/she felt itchy when he/she did not get his/her showers. He/She felt like he/she didn't matter. He/She worried he/she stinks and may offend others. 3. Review of Resident #88's care plan, revised 12/30/25, showed the resident was totally dependent on staff for bathing/showering. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident had moderately impaired cognition;-The resident required substantial/maximal assistance from staff with showering/bathing. Review of the resident's shower schedule showed the resident's scheduled shower days were Mondays and Thursdays. Review of the resident's shower sheets for May 2026 showed Certified Medication Technician (CMT) W gave the resident a shower and cleaned the resident's nails on 06/04/26. Observation on 06/07/26 at 4:45 P.M. (three days since the resident's last documented shower) showed the resident's nails were approximately 1/2-1 inch long, curved, uneven, and dirty with brown debris underneath. Observation on 06/09/26 at 6:00 A.M. (five days since the resident's last documented shower) showed his/her nails were approximately 1/2-1 inch long, curved, uneven, and dirty with brown debris underneath, and his/her hair was disheveled and oily. During an interview on 06/23/26 at 11:27 A.M., CMT W said the following:-The resident never refused his/her showers;-The resident would not let him/her file or clean his/her nails; -The resident sometimes let him/her clean his/her nails in the shower, but the resident never let him/her file or trim his/her nails. 4. Review of Resident #2's Care Plan, revised 3/19/26, showed the following:-The resident had an activity of daily living self-care performance deficit related to fatigue, limited mobility, and pain;-The resident required maximum assistance from one staff with bathing/shower two times weekly. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was cognitively intact;-The resident required maximum assistance for showering/bathing. During interviews on 6/08/26 at 1:15 P.M. and 6/11/26 at 9:29 A.M., the resident said the following:-He/She was scheduled for bathing on Wednesday and Saturday;-There were no scheduled shower aides on the weekends, so baths/showers scheduled for Saturday did not typically occur. -The regular shower aide was on a vacation last week;-He/She did not get his/her shower on Saturday (06/06/26) and did not get one earlier in the week because the shower aide was on vacation. 5. Review of Resident #37's care plan, revised 9/15/25, showed the following:-The resident had an ADL self-care performance deficit;-The resident was independent to supervision for bathing/showering; Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident was cognitively intact;-The resident required supervision for showering/bathing. During interviews on 6/7/26 at 2:16 P.M. and 6/8/26 at 1:03 P.M., the resident said the following:-He/She was scheduled to received a shower on Wednesday and Saturday;-He/She was supposed to get two showers per week, but he/she only received one shower a week over the last few weeks;-He/She generally did not get a shower on Saturdays due to staffing. 6. During an interview on 6/10/26 at 11:59 A.M., Certified Nurse Assistant (CNA) N said the following:-He/She was the full time shower aide for the 100, 200 and half of the 300 hall;-If he/she was not working it was the responsibility of the floor aides to complete the showers. During an interview on 6/15/26 at 4:06 P.M., CNA L said the following:-The full-time shower aide generally gave all the showers;-If there was not a shower aide scheduled, the aide assigned to the hall was responsible for giving the shower. During an interview on 6/15/26 at 4:39 P.M., Licensed Practical Nurse (LPN) Supervisor M said the following:-There was a full time shower aide scheduled for Monday through Friday;-The aide assigned to the residents' halls were responsible for giving showers on Saturdays. MO2997391

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper settings were in place for pressure reducing and relieving low air loss (LAL) mattresses (mattress that provided a constant flow of air in the mattress to help prevent pressure ulcers) to prevent the potential for development and worsening of pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or friction) for three residents (Residents #8, #44 and #70) in a review of three residents reviewed for pressure ulcer care. The facility census was 83. Review of the Resident Assessment Instrument (RAI) manual, updated 10/2025, showed the following:-Stage I - An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: Skin temperature (warmth or coolness); Tissue consistency (firm or boggy); Sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.-Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.-Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but 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.-Stage IV - 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 or tunneling.-Unstageable pressure wound - Slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined.-Suspected deep tissue injury - Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. Review of the facility policy, Support Surface Guidelines, revised 10/24/22, showed the following:-The facility will select the appropriate pressure reducing and relieving devices for residents at risk of skin breakdown;-Pressure Reducing Support Surface (also known as Pressure Redistribution Support Surface) is a surface designed to prevent or promote the healing of pressure ulcers by distributing pressure over a larger surface area of the body in an effort to reduce or eliminate tissue pressure in a more circumscribed location.-The facility will provide care and services to promote the prevention of pressure ulcer development.-Low-air-loss mattresses are giant air-permeable pillows that are continuously inflated with air. The air flow has a drying effect on tissues. Low air loss mattresses will be set per manufacturer guidelines or per resident's preference/comfort. Review of the undated user manual for the facility's low air loss mattresses showed the pump and mattress are intended to reduce the incidence of pressure ulcers while optimizing patient comfort. (The User Manual did not address the weight settings for the pump and mattress.) 1. Review of Resident #8's annual Minimum Data Set (MDS, a federally mandated assessment instrument), dated 04/03/26, showed the following:-He/She had moderately impaired cognition;-He/She required partial/moderate assistance from staff for bed mobility rolling left to right;-He/She had one or more unhealed pressure ulcer/injuries;-He/She received pressure ulcer/injury care;-He/She used a pressure reducing device for his/her bed. Review of the resident's care plan, revised 05/29/26, showed the following:-He/She required a low air loss mattress with bolsters to promote wound healing;-He/She needed a low loss air mattress to protect the skin while in bed;-He/She needed monitoring and assistance to turn/reposition. Review of the resident's wound evaluation and management summary, dated 05/29/26, showed the following:-Stage IV pressure ulcer (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 or tunneling) of the left ischium (lower and back part of the hip bone) full thickness;-Wound size: 7.5 centimeters (cm) length, 5.4 cm width, 3.7 cm depth;-Duration: greater than 92 days;-Support surface: bed - group two (a pressure-reducing mattress system that is medically required to treat or prevent advanced bed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sores);-Wound progress: exacerbated;-One or more signs of clinical infection;-Recommended for transfer to hospital for further care. Review of the resident's progress note, dated 06/04/26 at 6:57 P.M., showed he/she returned to the facility from the hospital with a diagnosis of osteomyelitis (bone infection) of sacrum (triangular bone located above the coccyx) and was on antibiotics with a wound vac (vacuum-assisted closure used to conduct negative pressure wound therapy to promote healing) in place. Observation on 06/07/26 at 2:30 P.M. showed the following:-The resident lay on his/her back in bed on a low air loss mattress (LAL);-The LAL mattress pump was set at 308 pounds. During an interview on 06/07/26 at 2:30 P.M., the resident did not respond when asked if his/her bed was comfortable. Review of the resident's electronic health record, dated 06/08/26 at 1:59 P.M., showed the resident's current weight was 157.2 pounds. Observation on 06/09/26 at 6:10 A.M. showed the following:-The resident lay on his/her back in bed;-The LAL mattress pump was set at 308 pounds. During an interview on 06/22/26 at 12:48 P.M., the resident's responsible party said the resident complained about the pain in his/her buttock/leg area a lot when he/she sat or laid on his/her bottom. 2. Review of Resident #44's Care Plan, updated 10/22/25, showed the following:-Stage III pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible but 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) right buttock -The resident preferred to be positioned on his/her back;-The resident required pressure relieving/reducing device on bed/chair;-Turn and reposition. Review of the resident's annual MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Diagnoses include osteomyelitis (infection in the bone);-Dependent on staff to roll left and right;-Weight 102 pounds;-One or more unhealed pressure ulcer/injury;-One stage III and one stage IV pressure ulcer, not present on admission;-Pressure reducing device for bed. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Weight 106 pounds;-One stage IV pressure ulcer not present on admission;-Pressure reducing device for bed. Review of the resident's Care Plan, updated 02/24/26, showed LAL mattress to the resident's bed. Review of the resident's Care Plan, updated 03/10/26, showed the resident has a stage IV pressure ulcer to his/her sacrum. Review of the resident's Care Plan, dated 03/10/26, showed a deep tissue injury to the resident's left lateral plantar foot (the bottom, outer edge of the foot). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Weight 104 pounds; -One or more unhealed pressure ulcer/injury;-One stage IV pressure ulcer not present on admission, one unstageable deep tissue injury (new) not present on admission;-Pressure reducing device for bed. Observation on 06/09/26 at 6:30 A.M., showed the following:-The resident lay on his/her back in his/her bed;-The resident's LAL mattress pump was set to 220 pounds. Observation on 06/09/26, at 10:37 A.M., showed the following:-The resident lay on his/her back in his/her bed;-The resident's LAL mattress was set to 220 pounds;-The Corporate Wound Nurse, the Director of Nursing (DON) and the Wound Physician were present to assess the resident's wound;-The Corporate Wound Nurse turned the resident on his/her right side;-There was an open wound, approximately the size of a ping pong ball;-The Wound Physician measured the wound and said it measured 3.5 cm in length, 3.3 cm in width, and 1.7 cm in depth. The wound also had 2.2 cm of undermining (tissue beneath the skin's edges dies and erodes away, creating a hidden pocket or gap beneath the surface) at the top of the wound;-The dressing had a moderate amount of greenish drainage, and the wound bed was a dull pink with muscle and fascia (connective tissue) was visible. 3. Review of Resident #70's Care Plan, dated 05/21/24, showed the following:-The resident had potential/actual impairment to skin integrity;-Pressure relieving mattress to protect the skin while in bed.-An update on 12/23/25, showed the resident had a stage III pressure ulcer on his/her right heel;-An update on 03/17/26 showed the resident had a stage III pressure ulcer on his/her first right metatarsal head (end of the long bone in the foot near the toe). Review of the resident's quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment. The weighed 152 pounds and had one unhealed stage III pressure ulcer. Review of the resident's Care Plan, updated 04/07/26, showed the stage III pressure ulcer on the resident's first right metatarsal head was resolved. Review (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the resident's Care Plan, updated 04/14/26, showed the right heel stage III pressure ulcer was resolved. Review of the resident's weight record, dated 06/01/26, showed the resident weighed 155.8 pounds. Observation on 06/08/26 at 9:52 A.M., showed the resident lay in bed on a LAL mattress. CNA D and CNA E positioned the resident on his/her back. The LAL pump on the end of the resident's was set at the highest setting past 300 pounds. The LAL mattress was firm and barely flexed when pressure was applied. The resident's right heel was reddened. CNA D said the resident's right heel felt squishy. Observation on 06/09/26 at 6:30 A.M., showed the resident lay on his/her back in his/her bed. The resident's LAL mattress felt firm and did not flex with pressure. The LAL mattress pump was set at the highest setting past 300 lbs. 4. During an interview on 06/09/26, at 10:40 A.M., the Wound Physician said he expected staff to set the LAL mattress to the resident's weight unless the resident was uncomfortable, then staff should adjust the setting to the resident's comfort. Setting the mattress to the resident's weight was preferred and gave the most pressure reduction. During interviews on 06/09/26 at 10:45 A.M. and on 06/11/26 at 5:19 P.M., the Director of Nursing (DON) said the LAL mattress pumps should be set to the resident's weight and to manufacturer guidelines to ensure pressure reduction and promote wound healing. The mattress should not be set on the highest setting and could cause more pressure. During an interview on 06/22/26 at 1:03 P.M., the Medical Director said the following:-The higher weight setting would be a much harder surface than he would expect for wound healing;-He expected staff to set the LAL mattress at the proper weight for the residents. MO2997391

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure staff utilized a gait belt and locked the wheelchair brakes prior to transferring one resident (Resident #4), in a review of 23 sampled residents. Staff did not put a gait belt on the resident when assisting the resident to from the toilet to the wheelchair. Staff did not lock the wheelchair brakes, the wheelchair moved as the resident went to sit in the wheelchair, and the resident fell to the floor. The resident fractured his/her proximal left humerus (the upper end of the upper arm bone, commonly known as a broken shoulder). The facility census was 83. On 06/11/26, the Administrator was notified of the past non-compliance which occurred on 02/23/26. Following the resident's fall on 02/23/26, the facility immediately assessed the resident, notified the resident's medical provider, and sent the resident to the hospital for evaluation. On 02/23/26, the facility conducted an investigation following the resident's fall. On 03/02/26, staff in serviced the certified nurse assistant (CNA) involved when the resident fell regarding gait belt use. On 03/30/26, the facility in serviced all staff on the facility's fall prevention policies. On 05/31/26, the facility in serviced all direct care staff on the facility's transfer policy which addressed pivot transfers using a gait belt and locking the wheelchair brakes prior to the transfer. The deficiency was corrected on 05/31/26. Review of the facility undated policy, Transfer Policy, showed the following:-Safe and efficient transfers are combination of the resident's physical ability and perceptual capacity, proper equipment, appropriate techniques and good planning;-Transfers may involve assistive devices. Assistive devices include gait belts (a device used to transfer residents from one position to another);-When conducting a pivot transfers: -Apply the gait belt around the resident's waist; -Place the resident's wheelchair at a slight angle; -Lock the wheelchair brakes; -Hold the gait belt and provide the necessary assistance to help the resident stand; -Help the resident to pivot to stand in front of the chair; -Instruct the resident to reach back for the arms of the chair and to sit when he/she felt the edge of the seat against the back of the legs; -Remove the gait belt when the resident is safely in the chair. Review of Resident #4's Care Plan, dated 10/28/25, showed the resident required assistance from one staff for toileting and transfers. Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument), dated 02/18/26, showed the resident was cognitively intact, had a history of a stroke with hemiplegia (paralysis on ones side of the body), and required substantial/maximal assistance from staff to stand and to transfer to and from the toilet. Review of the resident's Nurses Note, dated 02/23/26 at 2:05 P.M., showed the resident was on the bathroom floor in his/her room. The resident said he/she attempted to transfer to his/her wheelchair after using the bathroom. The resident complained of pain and rated the pain in his/her left shoulder a 10 out of 10 (on a scale of zero to 10 with 10 being the most pain). The resident was sent to the hospital. During an interview on 06/10/26, at 1:52 P.M., the resident said he/she broke his/her arm because a CNA did not lock the wheelchair brakes, and he/she did not have a gait belt on. He/She went to sit down, and the wheelchair moved. The CNA was with him/her when he/she fell. During an interview on 06/10/26, at 2:30 P.M., CNA J said he/she was with the resident when the resident fell. He/She tried to get the resident positioned correctly. He/She went to go around the resident's wheelchair, and the resident fell down. He/She was not sure if the wheelchair was locked appropriately. The resident did not have a gait belt on during the transfer. The facility in-serviced him/her on gait belt use after the fall. Review of the facility investigation, dated 02/23/26, showed the following:-The resident had a fall with injury;-The resident transferred from the toilet to his/her wheelchair with the guidance of CNA J;-The resident said CNA J moved the chair toward the resident;-The resident said he/she went to sit in the wheelchair, the chair moved, and he/she fell to the floor;-The resident said he/she was not sure if CNA J locked the wheelchair brakes, the chair moved, and he/she fell to the floor;-The resident went to the emergency room, and the x-ray revealed a fracture to the resident's left proximal (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	humerus;-Statement from the resident, dated 02/23/26, showed he/she was getting up off the toilet. He/She thought the wheelchair was not locked and it moved a lot, then he/she went down to the floor. CNA J and the resident confirmed they were ready for the transfer. The resident grabbed the grab bar and stood. The resident asked CNA J if he/she was angled toward the wheelchair and the CNA said, not yet, go a little more, so he/she did. The CNA said he/she would move the chair to the resident. CNA J moved the chair. The resident went to sit down, and the chair moved. The resident went down to the floor. The nurse took his/her vital signs and the staff put a gait belt on him/her. The staff said they were going to use the gait belt to get him/her up and they did. -Statement from CNA J, dated 02/23/26, showed he/she was getting the resident off the toilet. When the resident went to sit in his/her wheelchair, he/she wasn't in the wheelchair correctly. He/She told the resident to hold on as he/she walked around to get the resident situated better. By the time he/she got around the resident, the resident was on the floor. He/She did not see the resident fall.-Conclusion: The resident fell during a transfer with CNA J. The resident said his/her chair moved when he/she attempted to sit down and could not remember if his/her wheelchair brakes were locked. The resident was sent to the hospital and diagnosed with a fracture of the left proximal humerus; a. The facility initiated the following interventions related to the accident: b. Nurse Practitioner assessed the resident at the time of the incident; c. Head-to-toe assessment completed; d. Resident sent to the emergency room; e. X-ray results revealed a fracture of his/her left humerus; f. Resident was sent back to the facility with new orders; g. Therapy to evaluate; h. In-Servicing initiated to enhance facility processes.-The investigation included the resident's assessment and review of medical records;-In-service included in the investigation, dated 03/02/26, showed CNA J signed an in-service form that stated, Gait belt should be placed prior to transferring a resident.-In-service for fall prevention included in the investigation, dated 03/30/26, showed it reviewed fall prevention to include the following: a. Prevent falls by anticipating resident needs, the six P's: b. Pain, assess pain and provide intervention if needed; c. Potty, offer toileting assistance, never assume a resident will call; d. Possessions, ensure call light, phone, water, glasses, and personal items are in reach; e. Positioning, reposition for comfort and safety, and bed in lowest position; f. Personal needs, ask if residents need anything else before leaving; g. Pick up, are any items on the floor, look for trip hazards;h. Encourage the use of the call light, keep pathways clear of clutter, ensure non-skid footwear is on, anticipate needs before residents try to get up, consistent rounding prevents falls, resident safety starts with us;i. The in-service record included a note to review the fall policy and emails and electronic receipt to staff. Review of the facility's in-service documentation showed the facility conducted an in-service related to transfers for all direct care staff on 5/31/26. The in-service included a review of the transfer policy which addressed pivot transfers using a gait belt and locking the wheelchair breaks. During an interview on 06/10/26, at 4:12 P.M., the Director of Nursing (DON) said the following:-She was not the DON at the time the resident fell;-She expected staff to use a gait belt every time they assisted a resident with a transfer. Staff were to lock wheelchair brakes prior to transferring a resident to a wheelchair. MO3018141

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	265589	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Rehab and Healthcare Center	230 Spencer Road Saint Peters, MO 63376

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to maintain documentation to show the facility used the services of a registered nurse (RN) in the facility for eight consecutive hours a day, seven days a week. The facility census was 83. During an interview on 06/11/26 at 5:37 P.M., the Administrator said the facility did not have a policy addressing RN coverage. Review of the facility assessment, updated on 07/20/25, showed to use the services of a registered nurse for at least eight consecutive hours a day, seven days a week. Review of the facility provided timecard punches, payroll reports and schedules for Sunday, 04/05/26, showed no RN coverage. Review of the facility provided timecard punches, payroll reports and schedules for Sunday, 04/26/26, showed no RN coverage. During an interview on 06/18/26 at 10:31 A.M., the Scheduler said the following:-She was responsible for staffing and ensuring RN coverage for the facility;-She was aware there was to be an RN in the building for eight consecutive hours each day;-The facility employed three RNs and utilized agency staff when available;-She was aware there were times the facility did not meet the requirement due not being able to find an RN available to work. During an interview on 06/11/26 at 12:20 P.M., the Director of Nursing (DON) said the following:-She was aware of the requirement to have an RN for eight consecutive hours a day;-The Scheduler was responsible for scheduling the RNs;-She had reviewed the list of uncovered days the state agency provided, and she did not see the facility had RN coverage for the days listed. During an interview on 06/11/26 at 12:36 P.M., the Administrator said the following:-She was aware of the requirement to have an RN for eight consecutive hours a day;-The Scheduler was responsible for ensuring the facility met the RN coverage requirement;-She expected the facility to follow the regulations for RN coverage;-She had reviewed the list of uncovered days the state agency provided, and she did not see the facility had RN coverage for the days listed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review for each nurse aide at least once every 12 months and provide regular in-service education based on the outcome of the reviews. The facility identified six CNAs were employed by the facility for more than a year. Four of six CNAs reviewed did not have the required performance review or documentation of in-servicing education based upon the outcome of the review. The facility census was 83. During an interview on 06/11/26 at 5:37 P.M., the Administrator said the facility did not have a policy to address nurse aide annual performance reviews. Review of the Facility Assessment Tool, dated 07/20/25, showed the following:-Required in-service training for nurse aides. In-service training must address areas of weakness as determined in nurse aides' performance reviews and facility assessment. 1. Review of Certified Nurse Assistant (CNA) AA's employee file showed the following:-He/She was hired on 04/08/25;-No documentation the facility completed an annual performance review for CNA AA since his/her date of hire. 2. Review of CNA BB's employee file showed the following:-He/She was hired on 05/07/25;-No documentation the facility completed an annual performance review for CNA BB since his/her date of hire. 3. Review of CNA Z's employee file showed the following:-He/She was hired on 03/11/25;-His/Her employer evaluation, dated 03/11/26, showed he/she received a fair rating for work quality and dependability. There were no additional comments to further explain the reason for the fair rating. The evaluation section did not include any additional comments or evidence of any additional in-servicing;-There was no documentation to show staff educated CNA Z based on the outcome of his/her annual performance review. 4. Review of CNA CC's employee file showed the following:-He/She was hired on 10/28/24;-His/Her employer evaluation, dated 10/28/25, showed he/she received a fair rating for dependability. There were no additional comments to further explain the reason for the fair rating. The evaluation section did not include any additional comments or evidence of any additional in-servicing;-There was no documentation to show staff educated CNA CC based on the outcome of his/her annual performance review. 5. During an interview on 06/11/26 at 09:20 A.M., the Director of Nursing (DON) said the following:-She assumed the role of DON in May 2026;-She was staff were to complete annual performance reviews and were to provide education on the areas the staff was found to be deficient in. During an interview on 06/11/26 at 12:36 P.M., the Administrator said she expected staff to complete an annual performance review for all CNAs. Human Resources, the department heads, and the Director of Nursing were responsible to complete the annual performance reviews. She was not aware staff did not complete the performance reviews.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control practices, facility policy, and the resident's care plan to prevent the development and spread of infection for one resident (Resident #8), in a review of 23 sampled residents. Staff failed to keep the resident's urinary catheter drainage bag off the floor, failed to wear proper personal protective equipment (PPE) during high-contact resident care activities, and failed to follow hand hygiene procedures when providing personal care to the resident. The facility census was 83.Review of the facility policy, Care of Catheter, revised 10/24/22, showed collection bags (urinary catheter drainage bags) should always avoid contact with the floor. Review of the facility policy, Hand Hygiene, revised 10/24/22, showed the following:-Facility staff must wash hands with soap and water in the following circumstances: -After contact with intact and non-intact skin, clothing and environmental surfaces even if gloves are worn; -In between glove changes alcohol-based hand hygiene products can and should be used to decontaminate hands; -Immediately upon entering a resident occupied area (single or multiple bed room, procedure or treatment room) regardless of glove use; -Immediately upon exiting a resident occupied area (e.g., before exiting into a common area such as a corridor) regardless of glove use; -After removing personal protective equipment (PPE);-Hand hygiene is always the final step after removing and disposing of personal protective equipment;-The use of gloves does not replace hand hygiene procedures. Review of the facility policy, Personal Protective Equipment, revised 07/01/23, showed the following:-Facility staff wear a gown whenever performing tasks that would likely soil the staff's clothing with blood, body fluids, secretions, or excretions.-Prioritizing use of gowns for care activities where splashes and sprays are anticipated, including high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing such as, providing hygiene, changing linens, and changing briefs; Review of the facility policy, Standard and Enhanced Precautions, revised 07/01/23, showed the following:-Enhanced standard precautions will be implemented for residents with a known multidrug-resistant organism (MDRO, a bacteria that developed resistance to at least three distinct classes of antimicrobial drugs) and who are at high-risk for colonization and transmission;-Presence of indwelling devices such as a urinary catheter;-Wounds or presence of pressure ulcer (unhealed);-Functional disability and total dependence on others for assistance with activities of daily living. Review of the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 04/02/24, showed the following:-Enhanced Barrier Precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a MDRO or any resident who has a chronic wound and/or indwelling medical device) 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;-Enhanced Barrier Precautions shall be conducted during the following activities: -During high-contact resident care activities: -Bathing/showering; -Providing hygiene; -Changing linens; -Changing briefs or assisting with toileting; -Wound care: any skin opening requiring a dressing;-Gloves and gown prior to the high-contact care activity;-Face protection may also be needed if performing activity with risk of splash or spray. Review of Resident #8's care plan, revised 02/04/26, showed the following:-He/She required extensive assistance from one staff member for personal hygiene;-Meticulous hand hygiene before and after each encounter with resident and others;-He/She is on enhanced barrier precautions (EBP) for wound;-Staff will utilize PPE when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required for performing high contact resident care; -Stage IV pressure ulcer (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 or tunneling) on left ischium (lower portion of the hip bone) and uses a wound vacuum (vacuum-assisted closure used to conduct negative pressure wound therapy to promote healing);-Follow EBP. Put on gowns and gloves while providing cares. Must change PPE and perform hand hygiene between residents;-He/She had bowel and bladder incontinence. Clean peri-area with each incontinence episode. Review of the resident's Prospective Payment System (PPS) five-day Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 04/28/26, showed the following:-He/She was dependent on staff for toileting hygiene;-He/She was always incontinent of bladder and bowel;-He/She had one Stage IV (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 or tunneling) pressure ulcer. Review of the resident's physician orders, dated June 2026, showed the following:-Urinary catheter care every shift and as needed (PRN) with soap and water every shift for health maintenance;-When wound vac is not in place, cleanse wound with Vashe (wound cleanser) and pack dampened gauze roll with Vashe or saline into wound and cover with dry dressing two times a day and as needed every eight hours PRN for wound;-Calmoseptine external ointment 0.44-20.6% (menthol-zinc oxide); apply to sacrum/groin/buttock topically every shift for redness;-Amoxicillin-potassium clavulanate (antibiotic) tablet 875-125 milligrams (mg); give one tablet by mouth two times a day for wound infection for 8 days at 9:00 A.M. and 9:00 P.M. (original order dated 06/04/26). Observation on 06/07/26 at 2:30 P.M. showed the resident lay in his/her bed. The resident had a urinary catheter. The urinary catheter drainage bag was in a cloth bag and lay directly on the floor next to the resident's bed. Observation on 06/09/26 at 6:10 A.M. showed the resident lay in his/her bed. The resident's urinary catheter drainage bag was in a cloth bag and lay directly on the floor next to the resident's bed. Observation on 06/09/26 at 8:30 A.M. showed the following:-EBP signage hung outside the resident's room. PPE, including gowns, were in a three-drawer cart outside of the resident's room in the hallway.-Certified Medication Technician (CMT) S and Certified Nurse Aide (CNA) Y sanitized their hands, put on gloves, and without putting on a gown, repositioned the resident in bed;-The resident's urinary catheter drainage bag was in a cloth bag and lay flat on the floor beside the resident's bed. Observation on 06/09/26 at 10:25 A.M. showed the following:-CMT S and CNA Y sanitized their hands and put on gloves but did not put on gowns; -CMT S provided perineal care and catheter care for the resident, removed his/her gloves, and without performing hand hygiene, put on clean gloves; -The resident's urinary catheter drainage bag was in a cloth bag and lay flat on the floor on the beside the bed;-CNA Y assisted the resident to turn to his/her left side;-CMT S cleaned the resident's buttocks, removed the resident's incontinence brief, placed the soiled wipes and incontinence brief in the trash can, removed his/her gloves, and without performing hand hygiene, put a glove on his/her right hand; -The resident had a pressure ulcer on his/her tailbone with a wound vac in place over the pressure ulcer;-CMT S applied a barrier cream (skin protectant) to the resident's skin with his/her right gloved hand, removed the glove, and without performing hand hygiene, put on gloves;-CNA Y fastened the clean incontinence brief on the resident;-CMT S placed a pillow between the resident's legs and covered the resident with blankets. During an interview of 06/09/26 at 10:43 A.M., CNA Y said the following:-The EBP signage showed the PPE staff were to wear when residents had open wounds, infections, and catheters;-He/She should wear a gown and gloves when providing all cares with the resident. During an interview on 06/09/26 at 10:45 A.M., CMT S said the following:-He/She should wear a gown when providing care to the resident;-He/She should have performed hand hygiene in between dirty and clean tasks and in between glove changes;-The hook on the resident's urinary catheter drainage bag was broken, so staff should have place the bag in a pink plastic bucket. Staff should not put the urinary catheter drainage bag on the floor. During an interview on 06/11/26 at 5:20 P.M., the Director of Nursing (DON) said the following:-She expected staff to perform hand hygiene before going in and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of rooms, between dirty and clean tasks, and when they changed their gloves; -She expected staff to wear a gown when providing care to residents on EBP with a urinary catheter; -The resident's urinary catheter drainage bag should not be on the floor;-She expected the CNA to report the broken hook on the urinary catheter drainage bag to the nurse and the nurse to replace it. Staff should place the urinary catheter drainage bag in a tub until the nurse could address the broken hook. MO3018141

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure staff training needs, as identified in the facility assessment and the annual in-servicing calendar, were not met for five of five staff reviewed. The facility failed to maintain documentation staff completed 12 hours of inservice training annually. The facility census was 83. During an interview on 06/11/26 at 5:37 P.M., the Administrator said the facility did not have a policy addressing 12-hours of annual training. Review of the Facility Assessment Tool, dated 07/20/25, showed the following:-Required in-service training must be sufficient to ensure the continuing competencies and be no less than 12 hours per year. Training topics included: -Communication; -Resident Rights and facility responsibilities; -Abuse, neglect and exploitation; -Infection Control; -Culture change; -Dementia care; -Caring for the cognitively impaired; -Changes in condition; -Cultural competency; -Person-centered care; -Activities of Daily Living; -Disaster planning and procedures; -Medication administration; -Measurements (blood pressure, orthostatic blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, radial and apical pulse, respirations, recording intake and output and urine test for glucose/acetone; -Resident assessment and examinations; -Caring for residents with Alzheimer's; -Caring for residents with mental and psychosocial disorders; -Specialized care. Review of the facility's Education Calendar showed the facility would provide the following trainings:-January: Incident/Accident Prevention, Safety/Elopement and Pain Management; -February: Resident Rights, Confidentiality and Dignity and Privacy; -March: Infection Control, Bloodborne Pathogens, HIV, Hep B, Handwashing; -April: Emergency Preparedness, Disasters, Safety, Active Shooter; -May: Body Mechanics, Transfer Techniques and Gait Belt Use; -June: Nutrition/Hydration, Weight Loss/Dental Care and Dementia Care; -July: Death/Dying, Psychological Aspects of Aging and Advanced Directives; -August: Grievances/Complaints, Effects of Meds on the Elderly; -September: Skin/Pressure Ulcers, Reporting, Care and Prevention; -October: Abuse/Neglect, Burn Out, Reporting Guidelines, QAPI and Facility Assessment; -November: Restorative Care and Restraint Free Environment; -December: Compliance/Ethics, Code of Conduct, Harassment/Communication and Cultural Competency; -The form was designed to be a staff member specific form, indicated with a place to put the employee name in a box at the bottom of the form and where documentation of completion of orientation, education fair and staff meetings for each month could be documented as completed;(The education calendar did not address the following training topics as identified on the facility assessment: person-centered care; measurements (blood pressure, orthostatic blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, radial and apical pulse, respirations, recording intake and output and urine test for glucose/acetone); resident assessment and examinations; caring for residents with mental and psychosocial disorders.) Review of the facility education binder showed staff provided the following in-services in 2025 and 2026:-03/28/25- Infection Control: Review of policy, enhanced barrier precautions, peri-care, and hand washing;-06/22/25 - Reporting abuse and neglect;-07/24/25 - Death and dying, aspects of aging, and advanced directives;-08/28/25 - Abuse/Neglect;-09/19/25 - Abuse/Neglect;-09/24/25 - Abuse/Neglect;-10/03/25 -Abuse/Neglect;-10/30/25 - Abuse/Neglect, burn-out, and reporting guidelines;-12/1/25 - Enhanced barrier precautions, handwashing, peri-care, and infection control;-12/10/25 - Customer service;-01/12/26 - Fall prevention;-01/14/26 - De-escalation of behaviors, resident rights, abuse and neglect;-01/17/26 - Location of fire extinguishers, evacuation protocol, and location of emergency preparedness binder;-02/01/26 - Enhanced barrier precautions, infection control, and handwashing;-02/19/26 - Privacy, dignity, resident rights, abuse and neglect;-03/19/26 - Infection control, prevention program, handwashing, vaccines, and personal protective equipment;-03/24/26 - Contact precautions;-The record contained a sign-in sheet for each in-service;-The sign-in sheet included a space for each employee in attendance to print his/her name, (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	write his/her signature, list his/her title, and print which shift he/she worked. (The record did not include the hours of each in-service. The in-service binder did not show evidence the facility covered the topics identified on the Facility Assessment Tool or the Education Calendar.) 1. Review of Certified Nurse Assistant (CNA) BB's employee file showed the following:-His/Her hire date was 05/07/25;-No documentation he/she received 12 hours of inservice training annually. During an interview on 06/11/26 at 1:24 P.M., CNA BB said the following:-He/She did not regularly attend in-services;-He/She did not know when in-services were held;-He/She did not know he/she was required to attend 12 hours of in-service education each year covering specific topics related to the care of residents in a long-term care facility. 2. Review of CNA Z's employee file showed the following:-His/Her hire date was 03/11/26;-No documentation he/she received 12 hours of inservice training annually. 3. Review of CNA CC's employee file showed the following:-His/Her hire date was 10/28/24;-No documentation he/she received 12 hours of inservice training annually. 4. Review of CNA HH's employee file showed the following:-His/Her hire date was 07/08/24;-No documentation he/she received 12 hours of inservice training annually. 5. Review of CNA FF's employee file showed the following:-His/Her hire date was 04/11/25;-No documentation he/she received 12 hours of inservice training. 6. During an interview on 06/11/26 at 12:48 P.M., Assistant Director of Nursing (ADON) A said the following:-He/She and the Director of Nursing (DON) decided on the in-service topics or education to schedule;-Major in-services are held the last Thursday of every month;-Scheduled in-services should follow the education calendar and the facility assessment tool;-He/She kept all in-service training records, information, and attendance sign-in sheets in the in-service binder;-He/She did not track when individual certified medication aides (CMTs) and CNAs completed the required training. During an interview on 06/11/26 at 12:36 P.M., the Administrator said the following:-The facility should provide in-servicing for all staff on the topics listed in the Facility Assessment Tool and on the Education Calendar;-The ADON and DON provided most of the in-servicing. The ADON should track the in-service hours for each staff member to ensure they received the 12 hours of training as required by regulation.