STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265733	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns Place	3333 Brown Road Saint Louis, MO 63114

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect two residents from misappropriation of property when former Office Manager (OM) E had one resident write checks made out to OM E to pay for room and board instead of the facility (Resident #1). In addition, OM E mislead a family member make electronic transactions to the employee's personal account to pay for room and board (Resident #11). These monetary transactions were intended as payments for the facility's care and services. The sample was 11. The census was 55. The facility was notified on 7/1/25 of the past non-compliance. The facility terminated OM E. He/She did not return to work following suspension and has had no further engagement with the facility post-investigation. The facility updated their forms of payment accepted to checks, money orders, cash with a receipt at time of transaction for resident-related charges. In addition, the facility no longer accepted electronic peer-to-peer payments. The updated policy was included in their amended admission packet policy. Going forward, Administration will conduct monthly audits of all resident billing and payment reconciliation. The deficiency was corrected on 5/9/25.Review of the facility's undated Abuse Prevention policy, showed:-Each resident has the right to be free from mistreatment, neglect and misappropriation of property;-Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful use of resident's belongings or money;-If any employee is in question, employee shall be suspended during the rest of the investigation;-If an employee is named by an alert and oriented resident, employee may be terminated. 1. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/9/25, showed:-Cognitively intact;-No psychosis or delusional behaviors;-No functional impairment to upper extremities. Review of the resident's electronic health records showed:-admission date of 3/28/23;-Responsible party: Self;-Care Plan showed limited assist to mostly independent in the current functional performance;-Diagnoses included heart failure, kidney disease and diabetes. During an interview on 7/1/25 at 2:45 P.M., the resident said OM E had been assisting him/her with payments and had no issues in the past. The resident found out in May 2025 that the employee had been stealing money. He/She was approached by OM E in the beginning of May about dental and vision care services that were due. He/She told OM E no funds available in the bank at that time. OM E told the resident to go ahead and write the check, and OM E would take care of it. The resident found out an attempt was made to cash the check in a store across the street from the facility and it bounced. The resident was notified the facility started an investigation and terminated the employee.Review of the facility's photocopies of the resident's checks written to OM E and cashed, showed:-Check dated, 12/30/24, pay to the order of OM E, $197.00;-Check dated, 12/31/24, pay to the order of OM E, $197.00;-Check dated, 1/16/25, pay to the order of OM E, $394.00;-Check dated, 2/28/25, pay to the order of OM E, $188.00;-Check dated, 2/28/25, pay to the order of OM E, $394.00;-Check dated, 3/20/25, pay to the order of OM E, $900.10. 2. Review of Resident #11's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Independent with self-care and mobility. Review of the resident's electronic health records showed:-admission date of 3/1/23;-Responsible Party: Son;-Diagnoses included heart valve disorders, high blood pressure, major depressive disorder. During an interview on 7/3/25 at 10:12 A.M., the resident's Responsible Party (RP) said OM E would call on the 3rd of every month without fail. He/She worked close by the facility and finished work after banking hours. The RP would usually get cash from automated teller machine (ATM). He/She would mostly give OM E cash to pay the facility. He/She did not receive receipts. He/She had at least two cashier's check payments while the Administrator was present and provided receipts on those times. He/She notified the Administrator at one time that he/she had made cash payments to OM E. The Administrator told the RP to refrain from doing so and asked for the receipts. The RP said there were Cash App (a mobile payment service that allows users to send money peer to peer) transactions to OM E for payments to the facility and provided screen shots. The RP said he/she trusted OM E and did not think OM E was capable of taking people's money. Review of the Cash App transactions provided by the facility, showed:-7/2/24, OM E's name, note: payment sent;-8/2/24, Om E's name, note: facility name;-9/5/24, Om E's name, note: pension payments;-10/5/24, Om E's name, note: payment sent;-11/4/24, Om E's name, note: facility's name;-12/4/24, Om E's name, note: facility's name;-3/6/25, Om E's name, note: facility's name monthly care payment for resident. 3. On 7/2/25 at 9:28 A.M., attempts were made to contact OM E using two different telephone numbers on file. OM E could not be reached at either number provided. 4. During an interview on 7/1/25 at 12:06 P.M., and 7/3/25 at 2:30 P.M.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident was free from significant medication errors when the facility failed to administer ordered pain medication for one resident (Resident #5). The sample size was 11. The census was 55.Review of the facility's Medication Orders policy, revised 11/14, showed:-Each resident must be under the care of a licensed physician authorized to practice in this state and must be seen at least every sixty days;-A current list of orders must be maintained in the clinical record of each resident;-When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. Review of the facility's Controlled Substance Policy, revised 4/19, showed:-Policy Statement: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications;-Upon Administration: The nurse administering the medication is responsible for recording name of the resident receiving the medication, name, strength and dose of the medication, time of administration, method of administration, quantity of the medication remaining, and signature of nurse administering medication. Review of Resident #5's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/24/25, showed:-Moderately impaired cognition;-No hallucinations and delusions behavior;-Impairment on one side to lower and upper extremities;-Diagnoses included atrial fibrillation (heart rhythm disorder), high blood pressure, aphasia (communication disorder), hemiplegia or hemiparesis (weakness or paralysis on one side of the body), and depression. Review of the resident's electronic medication administration record (eMAR), for June 2025, showed:-Acetaminophen Oral tablet (used to relieve mild to moderate pain and fever), give 650 milligrams (mg) by mouth every 4 hours as needed for elevated temperature and pain;-Staff documented the medication as given one time for the month, on 6/21/25 at 12:46 A.M.;-Tylenol with Codeine #3 (used to help relieve mild to moderate pain) oral tablet 300-30 mg, give 1 tablet by mouth two times a day for pain, order date 3/25/25, discontinued date 6/8/25;-Oxycodone HCL (opioid pain reliever used to manage moderate to severe pain) oral tablet 5 mg, give one tablet by mouth three times a day related to hemiplegia and hemiparesis, start date 6/8/25; -No documentation to show Oxycodone HCl was administered until 6/25/25. The first dose was given on 6/26/25. The MAR showed blank boxes for all dates prior to 6/26/25;-On 6/28/25, the 8:00 A.M. and 12:00 P.M. doses were marked #9 by an agency staff, which according to the Chart Codes, #9 indicated Other/ See Progress Notes. No progress notes documented. Observation and interview on 7/1/25 at 12:40 P.M., showed the resident in bed, grimacing and complaining of left leg pain. He/She said he/she was in pain every day. He/She only received headache medicine, and it did not help with the severe chronic pain he/she experienced daily. During an interview on 7/1/25 at 12:47 P.M., Registered Nurse (RN) A said the resident just had his/her pain medicine. He/She would have the resident repositioned to help alleviate the pain. Observation and interview on 7/2/25 at 10:02 A.M., showed the resident sat up in a wheelchair, in the hallway, right outside of his/her room. The resident said he/she was in continuous pain and wanted to have stronger pain medications.During an interview on 7/2/25 at 10:06 A.M., RN A said the resident always complained of pain and it became worse and more excruciating when he/she needed to get up. The resident was on routine Tylenol #3 and which was replaced with Oxycodone HCl on 6/8/25 per physician's order. During an interview on 7/2/25 at 10:41 A.M., the Director of Nursing (DON) said the resident did not like to get up so he/she would complain of pain when up. The resident had an order for Tylenol #3 two times a day for a while, then it was changed to Oxycodone 5mg three times a day. She was not aware and did not know why there was no documentation in the eMAR from 6/8/25 to 6/25/25. She would do some research on what happened. She said there was a revision of the Oxycodone order on 6/26/25. The resident was seen by the pain management provider at least every three weeks, but the Primary Care Physician (PCP) prescribed the Oxycodone on 6/8/25. However, it was not active and did not show in the staff eMAR until 6/26/25. The DON said she was not certain how the order remained in queue or not activated. If the order was queued, the nurses or Certified Medication Technicians (CMTs) would not show as to be administered, until the physician un-queued the order. During an interview on 7/2/25 at 12:41 P.M., the Primary Care Physician (PCP) confirmed the Oxycodone HCl 5 mg order on 6/8/25. The psychiatrist recommended the medication to help with the resident not only for the pain but mostly for his/her behaviors. He/She placed orders in the resident's electronic medical record (EMR), then sent an electronic prescription to the pharmacy. Normally the pharmacy received the prescriptions immediately. He/She said there may have been a computer glitch, which could be a reason why the pharmacy did not receive his/her electronic