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	12/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and respect when a staff member used profanity while speaking on the phone while he/she was in a resident room (Residents #3 and #35) and when staff failed to pull the privacy curtain while providing perineal care (peri-care, cleansing of the genitals and anal area) for one resident (Resident #19). The census was 56. The sample was 22. Review of the facility's Confidentiality of information and personal property policy, revised October 2017, showed:-Policy Statement: The facility will protect and safeguard resident confidentiality and personal privacy;-Policy Interpretation and Implementation:-The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records; -The facility will strive to protect the resident's privacy regarding his or her: -Accommodations; -Medical treatment; -Personal Care. Review of the facility's Resident's Rights Policy, revised February 202, showed:-Policy Statement: Employees shall treat all residents with kindness, respect, and dignity;-Policy Interpretation and Implementation: -Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -A dignified existence; -Be treated with respect, kindness, and dignity. 1. Review of Resident #3's medical record, showed:-admission to the facility on 3/13/23;-Diagnoses included bipolar disorder (mood disorder that can cause intense mood swings), high blood pressure and anxiety disorder. Review of the resident's care plan in use during the survey, showed:-Focus: Current Functional Performance;-Goal: Resident's functional status will progress toward personal discharge goals during stay;-Interventions: Resident's performance: Dressing- Limited assist /one-person physical assist. Observation on 12/8/25 at 4:44 P.M., showed a staff member talking on the phone and using profanity while providing personal care to the resident as the resident lay in bed. The bedroom door was open, and the privacy curtain was not drawn. The resident's roommate, Resident #35, was in the room as the staff member provided personal care to Resident #3. The staff member could be heard outside the bedroom door cursing loudly. Upon entering the room, the Surveyor heard the staff member say That's fu-ked up. She needed that shit cuz. That's why she was doing that. The Surveyor turned around and walked out of the room. As the Surveyor waited in the hallway, the staff member could still be heard using profanity in the residents' room. The staff member walked out of the residents' room with the phone on speaker and up to his /her mouth/ear and could be heard using profanity as he/she walked down the hallway. During an interview on 12/8/25 at approximately 4:46 P.M., Resident #3 said he/she guessed the door should have been closed. During an interview on 12/9/25 at 6:00 P.M., The Administrative Assistant said the door should have been closed while the staff member provided personal care to Resident #3, and the staff member should not have been using profanity. 2. Review of Resident #19's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/15/25, showed:-Moderately impaired cognition;-Substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toilet hygiene (the ability to maintain perineal hygiene);-Partial/moderate assistance (helper does less than half the effort. Helper lifts, hold or support trunk or limbs or supports trunk or limbs but provides less than half the effort) for rolling left to right;-Always incontinent of bowel and bladder;-Diagnoses included atrial fibrillation (a-fib, irregular heart rhythm) or other dysrhythmia, high blood pressure and arthritis. Review of the care plan in use at the time of the survey, showed:-Focus: The resident has bowel and bladder incontinence related to impaired mobility;-Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date;-Interventions: Clean peri-area with each incontinence episode. Observation on 12/4/25 at 5:50 A.M., showed Nurse Aide (NA) G entered the resident's room. The resident's roommate was awake in his/her bed. NA G asked Resident #19 if he/she wanted to be changed, then unfastened the brief and provided perineal care. The NA did not pull the privacy curtain between the residents' beds. During an interview on 12/5/25 at 12:05 P.M., the resident said he/she preferred for the privacy curtain to be pulled, and the door closed when care was provided. During an interview on 12/9/25 at 4:35 P.M., the Director of Nursing said staff should pull the privacy curtain while providing care if the resident had a roommate. 2634756

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for two of two residents sampled (Residents #49 and #68). The census was 56.1.Review of the facility's admission and Discharge report, dated 12/3/25, showed between 8/1/25 and 12/1/25, there were 11 residents who transferred or discharged from the facility. 2. Review of Resident #49's progress note, dated 11/5/25 at 3:46 P.M., showed the nurse was alerted to the resident's room. Upon assessment, the resident could barely speak. When asked was it hard to breathe, the resident nodded his/her head. Doctor notified of transfer to the hospital. Review of the resident's undated census sheet, located in the electronic medical record, showed the resident discharged to the hospital on [DATE]. Review of the resident's medical record, showed no information regarding notification to the Ombudsman of the resident's transfer to the hospital. 3. Review of Resident #68's progress notes, dated 9/23/25 at 5:09 P.M., showed staff alerted the nurse that the patient's family took the resident out of the building to move out. Director of Nursing (DON) notified. Social Worker notified. Review of the medical record showed, no information regarding the Ombudsman was notified of the discharge. 4. During an interview on 12/1/25 at 11:02 A.M., a representative from the LTC Ombudsman said he/she looked for August, September, October and November of 2025 and they have not received any discharge/transfer notifications during those months. 5. During an interview on 12/9/25 at 1:25 P.M., Social Services (SS) said the Ombudsman should be notified of the discharges and transfers monthly. She did not have any documentation showing the Ombudsman were notified during the months from August to November. SS said sometimes she handed the discharge and transfer notifications to the Ombudsman while they were in the building, or she may send it to them, or she may notify them by phone. 6. During an interview on 12/9/25 at 4:35 P.M. the Administrative Assistant said the ombudsman should be notified of discharges and transfers. At one point, the facility was notifying them by e-mail.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident care plans were updated and accurate to reflect Resident needs. This failure affected three residents (Residents #45, #6 and #44), whose care plans did not accurately address recent falls with interventions and the use of side rails. The sample size was 22. The census was 56.Review of the facility's Care Plan policy, revised December 2016, showed:-A comprehensive person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident;-The comprehensive, person-centered care plan will: Include measurable and objective time frames; Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Identify the professional services that are responsible for each element of care; Enhance the optimal functioning of the resident by focusing on a rehabilitative program. 1. Review of Resident #45's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 10/11/25, showed:-Cognitively intact;-Moderate difficulty hearing, speaker has to increase volume and speak distinctly;-Diagnoses included: heart failure, diabetes and hip fracture;-Independent for chair/bed-to-chair transfer;-Supervision or touching assistance (helper provided verbal cues and or touching/steading and/or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) for sit to stand (mechanical lift);-Partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or supports trunk or limbs but provides less than half the effort) for toilet transfers and tub/shower transfer. During an interview on 12/3/25 at 3:00 P.M. the resident said he/she fell in July. He/She was being weighed and when he/she grabbed the bar on the scale to pull up, the bar came forward, and he/she fell and broke his/her hip. Review of the care plan in use at the time of survey, showed no documentation the resident fell or if he/she was a fall risk. No documentation of the resident's transfer status. During an interview on 12/9/25 at 2:05 P.M., the MDS nurse said she would be responsible for completing the care plans. Care plans were updated quarterly, with a significant change and as needed. The Director of Nursing (DON) and floor nurses could also update care plans. If a resident fell, that should be on the care plan along with interventions. The resident's transfer status should be on the care plan. The care plan should be complete, accurate and a reflection of the resident's care needs. 2. Review of Resident #6's electronic physician's order sheet (ePOS), showed an order dated 6/5/25, resident may have side rails for mobility and self-care. Review of the resident's quarterly MDS, dated [DATE], showed:-Mild cognitive impairment;-Impaired upper and lower extremities on both sides;-Required substantial/maximal assistance for transfers;-Diagnoses included fractures, dementia and seizures. Review of the resident's Bed Rail Assessment, dated 10/20/25, showed the use of bilateral side rails. Review of the resident's care plan, revised 11/18/25, in use during the time of the investigation, showed no information regarding the use of side rails. Observations on 12/3/25 at 10:41 A.M., 12/4/25 at 8:16 A.M. and 12/5/25 at 12:08 P.M., showed the resident lay in bed. Quarter length side rails were raised on both sides. 3. Review of Resident #44's Bed Rail Assessment, dated 10/20/25, showed:-Bilateral side rail placement;-Side rails/assist bar are indicated and serve as an enabler to promote independence. Review of the resident's care plan, revised 11/2/25, in use during the time of the investigation, showed no information regarding the use of side rails. Review of the resident's comprehensive MDS, dated [DATE], showed:-Cognitive impairment;-Dependent on staff for all transfers;-Diagnoses included cancer and dementia. Review of the resident's ePOS, showed an order, dated 10/20/25, may have side rails up for mobility and self-care. Observations on 12/3/25 at 10:41 A.M., 12/4/25 at 8:29 A.M., and 12/8/25 at 12:46 P.M., showed the resident lay in bed on his/her back. Full length side rails were raised on both sides. During an interview on 12/8/25 at 2:14 P.M., Certified Nursing Assistant (CNA) D said the residents used side rails for positioning and transfers. During an interview on 12/9/25 at 2:02 P.M., the MDS Nurse said care plans were updated quarterly and as needed and should reflect each resident's individual needs. The use of side rails should be included on care plans. 4. During an interview on 12/9/25 at 4:35 P.M., The DON said the care plan should include falls with interventions, transfer status and side rails. The care plans should be accurate and individualized for each resident's care needs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 31 opportunities observed, 8 errors occurred resulting in a 25.80% error rate (Residents #48, #59, #9 and #56). The census was 56.Review of the facility's Adverse Consequences and Medication Errors policy, revised April 2014, showed:-A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services;-Examples of medication errors include: Omission, unauthorized drug, wrong dose, wrong route of administration, wrong dosage form, wrong dug, and wrong time;-Failure to follow manufacturer instructions and/or accepted professional standards. 1. Review of Advair Diskus (inhaled medication, used to treat lung disease) manufacturer instructions obtained from Advair.com, showed, Advair can cause serious side effects, including fungal infection in your mouth or throat (thrush). Rinse your mouth with water without swallowing after using Advair to help reduce your chance of getting thrush. Review of Resident #48 quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/6/25, showed:-Cognitively intact;-Diagnoses included diabetes. Review of the resident's order summary report, showed:-A physician order dated 4/8/25: Dapagliflozin Propanediol (used to treat diabetes) 10 milligrams (mg) by mouth in the morning for diabetes mellitus (DM);-A physician order dated 6/29/25: Advair Diskus Inhalation Aerosol Powder BreathActivated 100-50 microgram/actuation (mcg/act), 1 puff inhale orally two times a day for COPD (chronic obstructive pulmonary disease, lung disease);-A physician order dated 5/3/25: Senna (stool softener) 8.6 mg, give 1 tablet by mouth two times a day for constipation. Observation on 12/4/25 at 8:52 A.M., showed Certified Medication Technician (CMT) J prepared the resident's morning medications. He/She placed the tablets from the multi-dose packet into a medicine cup. The medications Dapagliflozin and Senna were not placed in the medication cup. The CMT provided the resident his/her Advair inhaler prior to giving the tablets. The CMT did not provide water and instructions for the resident to rinse and spit after using the inhaler. The CMT then gave the medication cup with the tablets to the resident. The resident took the tablets and drank water. Review of the resident's Medication Administration Record (MAR) at approximately 10:00 A.M., showed the CMT did not document the medication Dapagliflozin as given and documented that Senna was given. At 11:20 A.M., MAR showed Dapagliflozin was documented by CMT J as given. During an interview on 12/4/25 at 11:23 A.M., the resident said the CMT did not come back and administer any other medications. At 11:28 A.M., CMT J said the medication Dapagliflozin was not available and was not given. He/She could not find the Senna in the medication cart drawer and it was not given. He/She said whatever medications were signed off means they were given. He/She did not have the resident rinse and spit out after using the Advair inhaler. During an interview on 12/9/25 at 12:54 P.M., Registered Nurse (RN) B said residents on Advair should be provided with water to rinse and spit out after using the medication. 2. Review of Resident #59's quarterly MDS dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included heart failure, kidney failure, and hyponatremia (low sodium/salt level). Review of the resident's order summary report, showed:-A physician order dated 8/18/25: Klor-Con Oral (Potassium Chloride), 20 milliequivalent (mEq), give 1 packet by mouth one time a day related to hypo-osmolality (excess water, levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia;-A physician order dated 6/2/25: Thiamine HCl (vitamin B1) 100 mg, give 1 tablet by mouth one time a day for supplement;-A physician order dated 6/9/25: Aspirin EC Delayed Release 81 mg by mouth one time a day for deep vein thrombosis/blood clot). Observation on 12/5/25 at 8:42 A.M., showed CMT K prepared the resident's morning medications. He/She placed the tablets from the multi-dose packet into a medicine cup. The medications Potassium Chloride, Thiamine, and Aspirin were not placed in the medication cup. The CMT documented these medications as given. He/She administered the medications in the cup to the resident, then proceeded to prepare another resident's medications. He/She did not obtain the three medications from any packaging or stock bottles. During an interview on 12/8/25 at 10:24 A.M., the Director of Nursing (DON) said if over the counter (OTC) medications were not available in the resident medication packets, she expected the staff to use the stock bottles. The DON said the facility should have aspirin and thiamine in stock. During an interview on 12/8/25 at 4:07 P.M., Licensed Practical Nurse (LPN) A said all resident medications should be administered as ordered. Staff should not document medication as given if medications were not available. If

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to accurately document medications administration on the Medication Administration Record (MAR) for two residents (Residents #48 and #59) and staff failed to document when a resident fell and was sent to the hospital for one resident (Resident#45). The sample was 22. The census was 56. Review of the facility's Physician Services policy, dated April 2013, showed physician orders and progress notes shall be maintained in accordance with current Omnibus Budget Reconciliation Act (OBRA, a federal law impacting Medicaid/SSI eligibility and funding for long-term care) regulations and facility policy. 1. Review of Resident #48's order summary report, showed:-A physician order dated 4/8/25: Dapagliflozin Propanediol (used to treat diabetes) 10 milligrams (mg) by mouth in the morning;-A physician order dated 5/3/25: Senna (stool softener) 8.6 mg by mouth two times a day for constipation. Observation on 12/4/25 at 8:52 A.M., showed Certified Medication Technician (CMT) J prepared the resident's morning medications. He/She placed the tablets from the multi-dose packet into a medicine cup. The medications Dapagliflozin and Senna were not placed in the medication cup. He/She then administered the medications to the resident. Review of the resident's medication administration record (MAR), showed CMT J documented the Dapagliflozin and Senna was given. During an interview on 12/4/25 at 11:23 A.M., the resident said CMT J did not come back and administer any other medications. At 11:28 A. M., CMT J said the medication Dapagliflozin was not available and was not given. He/She could not find the Senna in the medication cart drawer and it was not given. He/She said whatever medications were signed off means they were given. 2. Review of Resident #59's order summary report, showed:-A physician order dated 8/18/25: Klor-Con Oral (Potassium Chloride), 20 milliequivalent (mEq), give 1 packet by mouth one time a day;-A physician order dated 6/2/25: Thiamine HCl (supplement) 100 mg by mouth one time a day;-A physician order dated 6/9/25: Aspirin EC Delayed Release 81 mg by mouth one time a day. Observation on 12/5/25 at 8:42 A.M., showed CMT K prepared the resident's morning medications. He/She placed the tablets from the multi-dose packet into a medicine cup. The medications Potassium Chloride, Thiamine, and Aspirin were not placed in the medication cup. CMT K documented these medications as given in the electronic medical record and administered the medications in the cup to the resident. He/She did not obtain the three medications from any packaging or stock bottles. 3. During an interview on 12/8/25 at 4:07 P.M., Licensed Practical Nurse (LPN) A said all resident medications should be administered as ordered. If not given, staff document in progress notes the reasons medications were not given. 4. Review of the facility's Managing Falls and Fall Risk policy, dated March 2018, showed it failed to identify how staff should document when a resident falls. Review of Resident #45's care plan, in use at the time of survey, showed no documentation the resident had a history of falls or if he/she was a fall risk and no documentation of the resident's transfer status. During an interview on 12/3/25 at 3:00 P.M. the resident said he/she fell in July. He/She was being weighed, when he/she grabbed the bar on the scale to pull up, the bar came forward, and he/she fell and broke his/her hip. Review of the resident's hospital facility transfer sheet with admission date 7/22/25, showed presented to emergency department (ED) from his/her nursing home after a fall and left hip pain. Patient said that nursing staff was trying to weigh him/her, down he/she fell, and landed on his/her bottom, he/she has been complaining of left hip pain which is worse with any kind of movement. Review of the resident's progress notes dated 7/22/25, showed no documentation the resident fell and was sent to the hospital. During an interview on 12/9/25 at 12:53 P.M., Registered Nurse (RN) B said the CNA reported the resident was being weighed and he/she lost his/her balance and fell. The nurse assessed the resident. He/She would not let anyone touch him/her, he/she was complaining of pain in his/her leg/hip area, 911 was called and the resident went to the hospital. Falls are documented in fall risk management and in the progress notes. Falls should be documented. 5. During an interview on 12/9/25 at 4:35 P.M., the Director of Nursing said she would expect the medical record to be complete and accurate. Medications should be accurately documented. She audits the MARs weekly and corrects anything that needed to be corrected. Falls should be documented in risk management, which will pull a progress note over. 26020932603584