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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to the Center of Medicaid and Medicare Services (CMS) complete and accurate direct care staffing information for Fiscal Year Quarter Three 2025 (April 1 through June 30) and failed to enter nursing hours in the Payroll Based Journal (PBJ) 9/16/25 through 9/30/25. The census was 56. Review of the facility's Reporting Direct-Care Staffing Information (Payroll-Based Journal policy, dated October 2017, showed:-Policy statement: Staffing and census information will be reported electronically to CMS through the PBJ system in compliance with 6106 of the Affordable Care Act;-Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees;-Providers who are employed by the facility (including physicians) are included in direct-care staffing information; providers who bill Medicare directly are not included;-For auditing purposes, reported staffing information is based on payroll records, or other verifiable information;-Information may be uploaded to the PBJ system manually, or through a payroll time and attendance system, or a combination of both;-Manual entries are made only by designated personnel with training on the PBJ user interface;-Staffing data includes the number of hours worked each day by each staff member;-Census data is reported each fiscal quarter and includes resident census on the last day of each month of the quarter;-A manual log is available to record information should the facility experience temporary internet outage and cannot record staffing data directly to the PBJ system. This log may also serve as a tool to record data that will be manually uploaded quarterly. Review of the facility's PBJ Staffing Data Report dated Fiscal Year Quarter Three 2025 (April 1-June 30), showed:-Failed to submit data for the quarter, result triggered, definition: Trigger=no data submitted for quarter;-One star staffing rating, result triggered, definition: Trigger=star staffing rating equals 1;-Excessively low weekend staffing, result this metric is suppressed for this facility and quarter,-No Registered Nurse (RN) hours, this metric is suppressed for this facility and quarter;-Failed to have Licensed Nursing Coverage 24 hours/day, result this metric is suppressed for this facility and quarter;-Possible reasons for suppressed metrics: Invalid data, facility is too new to rate, and special focus facility. Review of the facility's validation report, dated 10/17/25, showed:-Submission date/time was 10/17/25 at 2:48 P.M.;-Submission file status: Received. Please check each file status below;-# of files processed: 1;-# of files accepted: 1;-# of files rejected: 0;-# of files submitted without facility authority: 0;-Total # of messages: 0. During an interview on 12/5/25 at 11:18 A.M., a CMS representative said the validation report does not confirm the data submitted was complete or accurate. It only confirms that some data was submitted with no fatal errors. The CMS representative suggested the facility run staffing reports that are available in [NAME] (system that provides quality measure information) using the job codes for the quarters dated April 1 through June 30, 2025, and July 1 through September 30, 2025. During an interview on 12/8/25, the Administrative Assistant said he has been submitting his PBJ information, and he has not received any errors. He provided the report for July 1 through September 30, 2025. He was unable to access the [NAME] job code report for April 1 through June 30, 2025. During an interview on 12/16/25 at 2:06 P.M., the CMS representative said the provider did not enter the Licensed Practical Nurse (LPN) hours after 9/16/25 and no Registered Nurse (RN) hours were provided from 9/16/25 through 9/30/25 in the PBJ.

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

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 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.

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 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. **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 (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure on-going resident centered therapeutic activities were provided to residents on the weekends as an integral part of their psychosocial well-being. In addition, the facility failed to ensure activities were offered to residents who required one on one activities (Residents #2 and #44). This deficient practice had the potential to affect all residents in the facility. The sample size was 22. The census was 56.Review of the facility's Activity Evaluation policy, revised June 2018, showed:-Policy Statement: In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities;-Policy Interpretation and Implementation: The resident's activity evaluation is conducted by Activity Department Personnel, in conjunction with other staff who evaluate related factors such as functional level, cognition and medical conditions that may affect activities participation. 1. Review of the facility's November 2025 Activity Calendar, showed:-On 11/1/25 at 7:00 A.M. tea and crumpets, 9:00 A.M. social time, 11:00 A.M. church service, 5:00 P.M. movie time and 7:00 P.M. Blues game;-On 11/2/25 at 9:00 A.M. social time, 10:00 A.M. exercise, 2:00 P.M. bingo and 6:00 P.M. movie time;-On 11/8/25 at 7:00 A.M. tea and crumpets, 10:00 A.M. reminisce, 6:00P.M. movie time and 7:00 P.M. Blues game;-On 11/9/25 at 7:00 A.M. tea and crumpets, 9:00 A.M. social time, 2:00 P.M. bingo;-On 11/15/25 at 7:00 A.M. tea and crumpets, 9:00 A.M. exercise, 7:00 P.M. Blues game;-On 11/16/25 at 9:00 A.M. exercise, 10:00 A.M. social time, 3:00 P.M. church service, 2:00 P.M. bingo;-On 11/22/25 at 7:00 A.M. tea and crumpets, 9:00 A.M. social time, 2:30 P.M. Blues game, 3:00 P.M. worship service;-On 11/23/25 at 7:00 A.M. tea and crumpets, 9:00 A.M. reminisce, 2:00 P.M. bingo, 7:00 P.M. movie time;-On 11/29/25 at 7:00 A.M. tea and crumpets, 9:00 A.M. card games, 2:00 P.M. board games, 3:00 P.M. worship service and 7:00 P.M. Blues game. During an interview on 12/4/25 at 9:17 A.M., four residents, who the facility identified as alert and oriented, attended the group meeting. All four residents said activities are offered during the week during the afternoons. On weekends, there were no activities. There were church services on occasion and someone came in one Saturday once per month for bingo. They were bored on the weekends and wanted more activities. During an interview on 12/5/25 at 7:37 A.M., Certified Nursing Assistant (CNA) D said he/she worked at the facility for over a year, and activities were not offered during the weekends. Someone may come to the facility on Sundays for church services and one resident's family member comes in about once a month on a Saturday for bingo. He/She had overheard residents express concerns regarding the lack of activities on the weekends and was not aware of any residents receiving one on one activities. During an interview on 12/8/25 at 1:33 P.M., the Activity's Director said he/she was the only staff person who worked in the activities department, and he/she worked Monday through Friday, from 8:00 A.M. to 4:00 P.M. There was no activity staff on the weekends. Church services were offered three Sundays per month. Weekend activities were self-directed. There were no structured activities offered during the weekends. One on one activities were provided for bed-bound residents. He/She had not had the time to do one on one activities and did not have a list of residents receiving one on one activities. He/She did not have any documentation of one on one activities provided. 2. Review of Resident #2's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 10/16/25, showed:-Cognitively intact;-No behaviors;-Diagnoses included heart failure and diabetes. Review of the resident's Activities assessment, dated 10/24/25, showed:-Resident attends activities of choice;-Resident does not attend any activities unless it's in the dining room. He/She attends bingo and attends the social events. He/She has come outside a few times. Resident likes to read and do word searches. Review of the resident's electronic physician order sheet (ePOS), showed an order dated 12/1/25, COVID isolation with droplet precautions in private room with all care and services to (continued on next page)

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be provided in room due to positive COVID test. During an observation and interview on 12/3/25 at 12:27 P.M., the resident lay in bed in an isolated unit. One other resident was on the unit. The resident's television was not working. He/She said he/she was placed on the unit a few days ago. He/She stared at the walls all day and all night because his/her television was not working and staff was afraid to enter the isolated area. The resident participated in activities when he/she was in his/her regular room. Staff was aware the television was not working and had not offered any one on one activities since he/she had been on isolation. During an observation and interview on 12/4/25 at 11:14 A.M., the resident lay in bed in an isolated unit. He/She said he/she was staring at the walls again today. The television was not working. During an interview on 12/5/25 at 7:37 A.M., CNA D said the resident had been on the isolated unit since the past Sunday. His/Her television was not working and staff was aware. There were no activities on the isolated unit. He/She was not sure why activities were not provided. 3. Review of Resident #44's Activity's assessment, dated 10/21/25, showed:-Resident attends activities of choice;-Resident does not attend activities. I have tried to get her to come to activities, but he/she refuses. I will keep trying. Review of the resident's care plan, updated 11/2/25, in use during the time of the investigation, showed:-Focus: I make my own activity choices;-Goal: To participate in the things I enjoy most if I choose to. I may need assistance from staff/family;-Interventions: Inform me of the daily activity and I will choose to attend. Assist me if needed to activity of choice if I prefer to participate. Encourage participation/socialization with others. Review of the resident's comprehensive MDS, dated [DATE], showed:-Cognitive impairment;-No behaviors;-Diagnoses included cancer and dementia. During an observation and interview on 12/3/25 at approximately 11:45 A.M., the resident lay in bed with no television or radio on in his/her room. The resident said he/she could not get the television to work and was not sure how long it was not working. At 11:53 A.M., Nursing Assistant (NA) I entered the resident's room. He/She said the resident's television was not working. He/She believed the resident had been in the room for three to four days without a working television. Observation on 12/3/25 at 5:39 P.M., showed the resident lay in bed in his/her bedroom. No lights, television or radio were on in the resident's room. When asked if the resident wanted to watch television, he/she said yes. Observation and interview on 12/5/25 at 12:13 P.M., showed the resident's family member in the resident's room holding the television remote controller. He/She said he/she was trying to fix the television and it had not been working. Staff was aware of the television not working. The resident could benefit from having a working television. 4. During an interview on 12/8/25 at 1:33 P.M., the Activity's Director said Residents #2 and #44 did not have working televisions and she was just made aware of it. Activities were also not provided for residents on isolation, as he/she was unable to go on the isolated unit due to health concerns. He/She was the only one in the activity department so the residents on the unit had not had any activities. 5. During an interview on 12/9/25 at 4:36 P.M., the Director of Nursing (DON) and the Administrative Assistant said activities were provided during the week for all residents. On the weekends, there were self-directed activities. Televisions were not a requirement. Although there was no documentation of residents receiving one on one activities, they have received it. They would expect activities to be provided to all residents, including residents on the isolation unit.

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, the facility failed to ensure Nursing Assistants (NAs) who were employed by the facility were certified within four months of hire, for four out of four sampled NAs. The census was 56. Review of the facility's Nurse Aide Qualifications and Training Requirements policy, dated August 2022, showed:-Policy statement: Nurse aides must undergo a state-approved training program;-Definition: Nurse Aide is any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay;-The facility will not employ any individual as a nurse aide for more than four (4) months full-time, temporary, per diem, or otherwise, unless: -That individual is competent to provide designated nursing care and nursing related services; and; -That individual has completed a training program and competency evaluation program, or a competency evaluation program approved by the state; -That individual has been deemed competent as provided in S483.1S0(a) and (b) of the requirements of participation. Review of the facility's current list of employees, hired since 3/20/24, showed:-NA L's hire date was 7/7/25;-NA M's hire date was 5/22/25;-NA N's hire date was 5/21/25;-NA O's hire date was 7/28/25. Review of the facility's daily staffing schedules dated 11/8/25 through 12/8/25, showed:-NA L was on the schedule on 11/10, 11/13, 11/14, 11/15, 11/16, 11/18, 11/19, 11/20, 11/21, 11/24, 11/25, 11/27, 11/28, 11/29, 11/30, 12/2, 12/3, and 12/4;-NA M was on the schedule on 11/10, 11/11, 11/13, 11/14, 11/16, 11/18, 11/19, 11/20, 11/21, 11/23, 11/24, 11/25, 11/27, 11/29, 11/30, 12/2, 12/3, 12/4 and 12/5;-NA N was on the schedule on 11/10, 11/11, 11/12, 11/13, 11/15, 11/16, 11/17, 11/19, 11/20, 11/24, 11/26, 11/27, 12/3,12/4 and 12/5;-NA O was on the schedule on 11/8, 11/9, 11/11, 11/12, 11/14, 11/25, 11/26, 11/27, 11/28 and 12/3. During an interview on 12/5/25 at 12:15 P.M., the Director of Nursing (DON) said NAs have four months to take their Certified Nurse Aid (CNA) test. Two NAs were taken off the schedule until they complete their test. The DON did not know who the NAs were that was taken off the schedule. If an NA failed their test or if the NA did not complete their test within four months, they would be terminated. The NAs have had a hard time getting their test scheduled because there are only three places in St. Louis for them to take their test. During an interview on 12/9/25 at 1:15 P.M., CNA P (CNA staffing supervisor) said the facility had NAs who worked at the facility. NAs must complete their test within 4 months. If they pass one of their tests, they can continue to work. NA O was no longer at the facility. NA L received a separation letter last week. NA M has scheduled his/her test and NA N took his/her knowledge test yesterday and had his/her other test scheduled for Friday (12/12/25). All four NAs worked past their four months. During an interview on 12/9/25 at 4:35 P.M. The Administrative Assistant said NAs cannot work if they have not completed their CNA test within four months. The NAs are having a hard time getting their test scheduled because there are hardly any testing sites in St. Louis. Two staff have completed their test, and one NA has a test date scheduled, and one NA was terminated. The staffing supervisor was responsible for tracking the NA time.

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

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 not given, document in progress notes the reasons medications were not given. 3. Review of the manufacturer's instructions for administering Tresiba insulin (long-acting insulin), dated July 2025, showed how do I use Tresiba flextouch pen:-Check the insulin type;-Attach a new needle;-Prime your pen (turn the dose selector to 2 units. Press and hold the dose button until the dose counter shows 0. Make sure a drop appears;-Select the dose;-Give the injection. Review of Resident #9's quarterly MDS, dated [DATE], showed:-Moderately impaired cognition;-Diagnoses included diabetes. Review of the order summary report, dated 12/5/25, showed, a physician order for Tresiba flextouch pen-injector 200 unit/milliliter (mL). Inject 14 units subcutaneous (under the skin) in the morning for diabetes. Observation on 12/4/25 at 10:05 A.M., showed Licensed Practical Nurse (LPN) H removed the Tresiba insulin pen from the drawer, cleaned the end of the insulin pen and placed the needle on the pen, then he/she turned the dial to 14 units and administered the insulin. The nurse did not prime the insulin pen. 4. Review of the Novolog Flexpen (short-acting insulin) manufacturers instruction for use, showed:-Pull pen cap straight off;-Check the liquid in the pen;-Select a new needle;-Push the capped needle straight into the pen and twist;-Pull off the outer needle cap;-Pull off the inner needle cap;-Turn the dose selector to select 2 units;-Hold the pen with the needle point up. Tap the top of the pen gently a few times to let any air bubble rise to the top;-Hold the pen with needle pointing up. Press and hold in the dose button until the dose counter shows 0;-Turn the dose selector to select the number of units needed to inject.-Choose injection site;-Insert needle into the skin;-Press and hold down the dose button until the dose counter shows 0. Review of Resident #56's admission MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included diabetes. Review of the order summary report, dated 12/5/25, showed:-A physician order for: Novolog flexpen 100 unit/mL, inject as per sliding scale: if 251 - 300 = 8 units subcutaneously with meals for diabetes;-A physician order for: Novolog injection solution 100unit/mL, inject 10 unit subcutaneously three times a day with meals related to diabetes. Observation on 12/4/25 at 9:25 A.M., showed LPN H completed the resident's fingerstick blood sugar test with a result of 254. At 9:45 A.M. LPN H removed the NovoLog insulin pen from the drawer, cleaned the end of the insulin pen and placed the needle on the pen, then he/she turned the dial to 18 units and administered the insulin. The nurse did not prime the insulin. During an interview on 12/9/25 at 12:53 P.M., Registered Nurse (RN) B said insulin should be primed then turn the dial to the amount of insulin to be administered. 5. During an interview on 12/9/25 at 4:35 P.M., the Director of Nursing (DON) said insulin pens should be primed before turning the dial to the amount to be administered. The staff should administer resident medications as ordered. 260218726020932603584

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with acceptable standards of practice. The facility identified one Certified Medication Technician (CMT) cart, one Nurse cart, one treatment cart and one medication room. Two out of the three carts and the medication room were checked for medication storage. Issues were found in the Nurse cart. The census was 56. Review of the facility's Medication Labeling and Storage policy, dated February 2023, showed:-The medication label includes, at a minimum: medication name (generic and/or brand); strength; and resident's name;-For over the counter (OTC) medications in bulk containers (if permitted by state law) the label contains: the medication name; strength; quantity; accessory instructions; lot number; and expiration date (if applicable);-Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.1. Observation on 12/5/25 at 8:10 A.M., in the top drawer of the Nurse cart, showed one out of two insulin pens were open and undated. There was a blue cup with two green oval tablets, with no resident name or label identifying what the medication was and one bottle of Senna (stool softener) that was open with no lid on the medication. Registered Nurse (RN) B said the insulin pen did not have a name on it and he/she did not know when it was opened. He/she could not explain why there were pills in a cup with no name or label or why there was no lid on the senna. The nurse removed and items from the medication cart and discarded them.2. During an interview on 12/9/25 at 4:35 P.M., the Director of Nursing said there should not be medications in a cup with no label on it and medication bottles should have a lid on them.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable infection control standards by not implementing Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for two residents (Resident #34 and #8). In addition, the facility failed to ensure staff used good infection control practices for one resident (Resident #19) when staff failed to perform hand hygiene between dirty and clean when personal care was provided and when staff placed the soiled brief and linens directly on the floor. The census was 56.Review of the facility's Implementing the use of EBP in Skilled Long Term Care Nursing Facilities policy, dated 2024, showed EBP should be used for residents with any of the following: indwelling devices (e.g., indwelling urinary catheter, feeding tube, and chronic wounds, that increase their risk of acquiring MDROs:-Recommendations for following EBP for nursing home staff based on care activities: Examples of care activities: providing care under clothes or dressings; taking the resident to the toilet or providing perineal care (peri care, cleansing of the genitals and buttocks area); and providing bed mobility, including rolling from side to side;-Infection control recommendation: Use hand hygiene, gown and gloves (high-contact activities). 1. Review of Resident #34's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/1/25, showed:-Moderately impaired cognition;-Total dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers) for toilet hygiene and chair/bed to chair transfer;-Had an indwelling urinary catheter;-Diagnoses included renal (kidney) insufficiency (partial kidney function failure), renal failure or end stage renal disease (ESRD, chronic irreversible kidney failure). Review of the care plan in use at the time of survey, showed:-Focus: the resident has an Activities of Daily Living (ADL) self-care performance deficit related to multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) diagnoses;-Goal: the resident will maintain current level of function in through the review date;-Interventions: Bed mobility, totally dependent on 1-2 staff for repositioning and turning in bed and as necessary; Dressing, totally dependent on 1 staff for dressing; Transfer, totally dependent on 2 staff for transferring, mechanical lift for transfers. Review of the resident's order summary report, dated 12/9/25, showed a physician order to change indwelling urinary catheter monthly and as needed. Observation of the resident's room, showed:-On 12/3/25 at 3:13 P.M. and 12/4/25 at 11:34 A.M., no EBP signage on the door nor any personal protective equipment (PPE) available inside or outside the resident's room;-On 12/5/25 at 7:13 A.M., the resident lay in bed. His/her urinary catheter drained to gravity. No EBP signage on the door nor any personal protective equipment (PPE) available inside or outside the resident's room. Observation on 12/5/25 at 7:35 A.M., showed Nurse Aide (NA) E and NA F entered the room, performed hand hygiene and put gloves on. NA E provided peri care, while NA F held the resident over on his/her side. They placed the mechanical lift pad under the resident. NA E emptied the resident's catheter drainage bag. Then, attached the lift cloth to the lift and transferred the resident from the bed to the chair. Neither NA wore a gown while providing care. 2. Review of Resident #8's significant change MDS, dated [DATE], showed:-Severe cognitive impairment;-Diagnoses included: high blood pressure, stroke and malnutrition, and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability);-Feeding tube while a resident. Review of the resident's care plan in use at the time of survey, showed:-Focus: the resident has unplanned/unexpected weight loss related to poor food intake3/22/24 weight has stabilized. New feeding tube placement related to malnutrition. Resident refused to eat related to paranoia;-Goal: the resident will consume 50% two of three meals/day;-Interventions included tube feeding as ordered. Review of the resident's physician (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order summary, dated 12/4/25, showed a physician order for Jevity 1.5 (nutrition supplement) at 60 milliliters (mL)/hour continuous. On at hour of sleep (HS) and off at 6 A.M., flush with 75 mL of water every 4 hours. Observation on 12/5/25 at 5:40 A.M., showed no EBP signage on the door nor any PPE available inside or outside the resident's room. The resident lay in bed. The tube feeding infused at 60 mL/hour. The resident said he/she was waiting for the nurse to come in and disconnect the tube feeding so he/she could get up. Observation on 12/5/25 at 6:00 A.M., showed Registered Nurse (RN) C entered the resident's room, performed hand hygiene and put gloves on. The nurse stopped the tube feeding and flushed the g-tube with 30 mL of water. The nurse did not wear a gown. Observation on 12/5/25 at approximately 6:15 A.M., showed NA G, performed hand hygiene and put on gloves. NA G assisted the resident to the toilet and with dressing. NA G did not wear a gown. 3. During an interview on 12/9/25 at 12:53 P.M., RN B said today was the first day he/she started wearing PPE (gown and gloves) for residents with feeding tubes. Prior to today, staff only wore PPE for catheter care. 4. Review of the facility's Peri Care policy, dated revised February 2018, showed wet washcloth and apply soap; wash perineal area, wiping from front to back; cleanse the genitals; continue to wash the perineum moving from inside outward to the thighs, Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. Review of Resident #19's admission MDS, dated [DATE], 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 supports 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 resident's care plan, in use at the time of survey, showed:-Focus: the resident had 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 NA G entered the resident's room and asked the resident if he/she wanted to be changed. NA G unfastened the resident's brief, went into bathroom to wet the washcloth, assisted the resident to roll towards the window, and removed the resident's brief. NA G placed the soiled brief directly on the floor, cleaned the resident's buttocks, and placed the soiled washcloth/towel on the floor. NA G placed a new brief under the resident and assisted him/her to roll back onto his/her back, cleaned the front, wiping front to back without using a new area of the washcloth after each wipe. NA G did not change his/her gloves and perform hand hygiene between dirty and clean areas. After he/she finished providing care, he/she picked up the soiled items off the floor and placed them in a plastic bag and removed them from the room. 5. During an interview on 12/8/25 at 2:07 P.M., Certified Nurse Aide (CNA) D said to provide peri care for a resident he/she would prepare a tub with some water and soap and use 3 towels. He/She would wipe the resident's peri area from front to back, using one wash cloth for each wipe. He/She was trained to use the four-corner method, fold the washcloth into 4 quarters, and use one corner for each wipe. CNA D said he/she did not think there were any residents who required EBP. 6. During an interview on 12/8/25 at 4:07 P.M., Licensed Practical Nurse (LPN) A said when staff provided peri care they should prepare 2 small trash bags, 1 for dirty and 1 for clean. Gather soap and enough towels. Wash using the 4-corner method, then rinse off with clean towels and dry off. Wash front to back. Place used or dirty towels in the bag, not on the floor and always do hand hygiene. 7. During an interview on 12/9/25 at 4:35 P.M., the Director of Nursing (DON) said residents who had catheters or feeding tubes were on EBP. The EBP signage was located on the PPE container on the resident's door. Staff should wear gown and gloves when they provide direct patient care such as dressing, personal hygiene and peri care. Residents #34 and #8 were on EBP. The facility used the four-corner method (a technique where a washcloth is folded into four sections (corners) to ensure a fresh, clean surface for each wipe, promoting hygiene and preventing cross-contamination) for peri care. Staff should place soiled items in a plastic bag.

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. 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 (continued on next page)

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	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

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 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. 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 (continued on next page)

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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