STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265824	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Post Acute	5400 Executive Centre Parkway Saint Peters, MO 63376

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff treated two sampled residents (Resident #1 and Resident #2) who had a diagnosis of Alzheimer's and dementia in a sample of 11 residents with dignity and respect. The facility census was 115.On 11/25/25 at 5:00 P.M. the Administrator was notified of the past non-compliance which occurred on 11/11/25 and 11/19/25. On 11/20/25 Family Member A provided the facility with a copy of the video from the ring camera in Resident #1's room, which showed Certified Nurse Aide (CNA A) providing care to the resident in a manner which violated the resident's rights to be treated with dignity and respect. CNA A was an agency aide, and the facility notified the agency on 11/20/25 the aide was not allowed to return to the facility. On 11/25/25 Family Member B provided the facility a video from the ring camera in Resident #2's room which showed CNA B providing care to the resident in a manner which violated the resident's rights to be treated with dignity and respect. CNA B was an agency aide, and the facility notified the agency CNA B was not allowed to return to the facility. The facility completed in-services of all staff on Resident Rights and Dementia on 11/20/25. The deficiency was corrected on 11/20/25. Review of the undated facility policy for Resident Rights showed employees shall treat all residents with kindness, respect, and dignity.Review of Resident 1's face sheet showed the was admitted to the facility on [DATE] resident with the diagnosis of dementia. Review of the resident's care plan for cognitive impairment with a revision date of 5/9/25 showed the following:- The resident exhibits cognitive loss related to dementia;-The resident will participate in facility activities and activities of daily living care as able;-Anticipate needs and meet them promptly, explain all care before providing to reduce resident tension and promote a comfortable experience. Review of the residents care plan for communication with a revision date of 5/9/25 showed the following:-The resident has impaired communication related to Alzheimer's disease;-Explain all cares before beginning, hearing impairment, increase volume of voice as needed; oriented to self only; use simple direct communication such as yes and not questions as needed. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 8/18/25 showed the following:-Usually able to make self-understood and usually understands others;-Unable to make decisions;-Has difficulty focusing attention and is easily distracted with no behaviors;-Dependent upon staff for Activities of Daily Living (ADL's) and transfers; -Incontinent of bowel and bladder. During an interview on 11/22/25 at 9:30 A.M. Family Member A said the following:-He/She has a camera in the resident's room;-He/She has supplied the facility with video footage of staff being rude, disrespectful and talking in a scolding voice toward the resident;-In September he/she sent video footage to the Administrator, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) of several staff members not talking with the resident while they were providing him/her care, just taking the resident's clothes off. The staff act like the resident knows and understands what they want the resident to do. The resident does not understand what staff want him/her to do, so he/she will show resistance when staff take his/her clothes off or push on him/her to roll over. Staff think the resident is defying them, but he/she does not understand. The resident deserves to be treated with dignity and respect. Review of the resident's ring camera video footage from 11/19/25 starting at 9:31 P.M. and ending at 9:45 P.M. provided by Family Member A showed the following:-Certified Nurse Aide (CNA) A and another CNA used a mechanical lift and transferred the resident to the bed; -Without greeting the resident or explaining to the resident what he/she was going to do, CNA A removed the resident's exposing the resident's legs and brief, then goes out of camera view with a towel and after several seconds returns to the bedside with a wet towel and tells the resident to roll towards the window. The resident looks at the staff member and does not roll. CNA A then pushes the resident by his/her leg to the left side. When the resident did not roll, the staff member released the resident's leg, and the resident relaxed. CNA A tells the resident, Do you understand what I am saying to you, do you understand what I am saying to you, I need for you to do what I am asking you to do. The resident looked at the staff member and did not reply; -CNA A leaves the resident laying on his/her back with his/her brief unfastened and the resident's perineal area exposed goes out of camera view and says, He/She doesn't do anything that I ask him/her to do; returns to the bedside and tells the resident I need you to do what I have asked you to do, I need to change your brief; -CNA A takes a wet towel and wipes the front of the resident's perineal area, then leaves the resident exposed for about 30 seconds. CNA A returns with a basin of water and a washcloth. CNA A removes the resident's brief, throws it on the floor and tells the resident, I will get you to do what I have

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the safety of two residents (Resident #1 and Resident #2), in a review of 11 sampled residents, who were dependent on staff for transfers and at risk for falls, when staff did not follow the facility policy and use two staff members when transferring the resident with a mechanical lift. The facility census was 115.Review of the facility policy for Mechanical Lift with a revision date of 7/2017 showed the following:-The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device;-At least two nursing assistants are needed to safely move a resident with a mechanical lift. 1.Review of Resident 1's face sheet showed the resident was admitted to the facility on [DATE] had diagnosis of dementia. Review of the resident's care plan for transfers with a revision date of 5/9/25 showed the following:-The resident required use of a mechanical lift with two person assist related to decreased mobility;-Explain all procedures prior to and utilize two persons to perform the transfers. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 8/18/25 showed the following:-Usually able to make self-understood and usually understands others;-Unable to make decisions;-Has difficulty focusing attention and is easily distracted with no behaviors;-Dependent upon staff for Activities of Daily Living (ADL's) and transfers. Review of the resident's ring camera footage, supplied by the resident's family from the resident's room, dated 11/19/25 at 12:27 P.M. showed the following:-Certified Nurse Aide (CNA) E and CNA F entered the resident's room to transfer the resident from the wheelchair to the bed via mechanical lift. Both staff members hooked the sling located under the resident to the mechanical lift;-CNA E then walked out of camera view as CNA F lifted the resident out of and above his/her chair with the lift, then moved the lift and the resident to the bed without the support of another staff;-As CNA F attempted to position the mechanical lift base under the bed, he/she moved the lift with the resident suspended, back and forth causing the resident to swing while up in the lift; the resident was not supported by any staff member;-When CNA F positions the legs of the lift under the bed, he/she began to lower the resident to the bed. At this point CNA E comes to the opposite side of the bed and grabs onto the sling as CNA F lowers the resident. Observation on 11/25/25 at 1:19 P.M. showed the following:-CNA E and CNA F take Resident #1 to his/her room to lay him/her down;-CNA F pushed the mechanical lift to the resident in the wheelchair and hooked the sling to the lift; he/she then began to lift the resident up off the wheelchair, then moved the resident in the lift over to the bed;-CNA E did not assist with the transfer and was getting supplies to provide incontinent care and looking in dresser drawers. When CNA F had the resident over the bed CNA E went to the opposite side of the bed and held onto the sling as CNA F lowered the resident onto the bed. During an interview on 11/25/25 at 1:25 P.M. CNA E and CNA F said the following-There should be two people when using a mechanical lift, one should hold onto the resident and the other should work the controls of the lift;-CNA E said he/she did not hold onto the resident, and he/she should have while CNA F was moving the resident in the lift. Review of Resident #2's face sheet showed the resident was admitted to the facility on [DATE] and diagnoses of Parkinson's disease (a progressive movement disorder of the nervous system. It causes nerve cells (neurons) in parts of the brain to weaken, become damaged, and die, leading to symptoms that include problems with movement, tremor, stiffness, and impaired balance), dementia and cognitive communication deficit (occurs when someone has trouble with one or more cognitive processes involved in communication). Review of the resident's comprehensive MDS dated [DATE] showed the following:-Usually able to make self-understood and usually able to understand others;-Unable to make decisions;-No behaviors;-Dependent upon staff for all ADL's. Review of the resident's care plan for ADL's/Mobility with a revision date of 10/13/25 showed the following:-At risk for ADL/mobility decline and requires assistance related to chronic disease progression, cognitive impairment;-Assist with transfers and bed mobility. Review of the resident's ring camera footage from the resident's room supplied by the resident's family member dated 11/20/25 at 3:36 P.M. showed the following:-CNA F and CNA G were in the resident's room and provided the resident with incontinent care while the resident was in bed;-CNA G positioned a mechanical lift sling under the resident;-CNA F got the mechanical lift and pushed it under the resident's bed; CNA F and CNA G secured the sling to the mechanical lift;-CNA G got a wheelchair and then sat in a chair with the wheelchair in front of him/her while CNA F attempted to pull the mechanical lift out from under the bed, the lift legs were caught under the bed, CNA F pulled back on the lift several times, causing the resident to swing while he/she was

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow current infection control standards for two residents (Resident #1 and Resident #2), in a review of eleven sampled residents when staff failed to perform proper hand hygiene and change gloves to prevent infection during personal care for Resident #1 and Resident #2. The facility census was 115. Review of the undated facility policy for Handwashing/Hand Hygiene showed the following:-This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections:-All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections;-All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors;-Indications for Hand Hygiene: immediately before touching a resident, after contact with blood, body fluids or contaminated services, after touching a resident, after touching the resident's environment. Review of Resident 1's face sheet showed the resident was admitted on [DATE] with a diagnosis of dementia. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 8/18/25 showed the following:-Usually able to make self-understood and usually understands others;-Unable to make decisions;-Has difficulty focusing attention and is easily distracted with no behaviors;-Dependent upon staff for Activities of Daily Living (ADL's) and transfers; -Incontinent of bowel and bladder. There were no care plans for incontinent care or infection control. Observation on 11/25/25 at 1:19 P.M. showed the following:-Certified Nurse Aide (CNA) E and CNA F entered the resident's room and without performing hand hygiene, took gloves from their pockets and put on their hands, then using a mechanical lift transferred the resident from the wheelchair to the bed;-CNA E removed the resident's pants and CNA G removed the resident's urine soaked brief;-Wearing the same gloves, CNA G opened the nightstand drawer and removed a package of briefs, placed them on the nightstand then took a couple of premoistened wipes and performed peri care for the resident then tossed the soiled wipes into a trash can;-Without removing the soiled gloves and performing hand hygiene, CNA G took a clean brief out of a package of briefs on the nightstand and put it on the resident;-Wearing soiled gloves CNA E and CNA G pulled the sheet and blanket up and covered the resident;-Wearing the same soiled gloves, CNA G then picked up the controls for the bed, lowered the bed, placed the call light on the bed, took his/her gloves off, and with out washing his/her hands removed the mechanical lift from the resident's room. During an interview on 11/25/25 at 1:25 P.M. CNA G said hands should be washed before resident care, apply gloves and then wash your hands when finished with resident care. 2. Review of Resident #2's face sheet showed the resident was admitted to the facility on [DATE] with diagnosis of Parkinson's disease (a progressive movement disorder of the nervous system. It causes nerve cells (neurons) in parts of the brain to weaken, become damaged, and die, leading to symptoms that include problems with movement, tremor, stiffness, and impaired balance). Review of the resident's comprehensive MDS dated [DATE] showed the following:-Usually able to make self-understood and usually able to understand others;-Unable to make decisions;-No behaviors;-Dependent upon staff for all ADL's;-Incontinent of bowel and bladder. Review of the ring camera video footage supplied by a family member dated 11/20/25 at 3:36 P.M. showed:-CNA G entered the resident's room with a pair of gloves on, went to the resident's bed and began to raise the bed up from the low position. While raising the bed up, took a cell phone that was on the nightstand and began to, what appeared to be texting then sat the phone back down on the nightstand;-CNA G with the same gloves on, then took a package of disposable wipes and a clean brief to the residents bed, removed the resident covers and pants. He/she then removed the residents brief which appeared to be urine soaked. CNA F then enters the resident's room with a pair of gloves on and a mechanical lift. CNA F took the soiled brief off the bed and tossed into a trashcan, then took the controls of the mechanical lift and raised the lift up, while with the same gloves on, CNA G pulled up the resident's pants, picked up the cell phone again, looked a the phone then placed the phone down on the night stand, then pulled a wheelchair up to a chair in the room, sat down in the chair and held onto the handles of the wheelchair;-With the same gloves on CNA F transferred the resident from the bed to the wheelchair using the mechanical lift, lowered the resident into the chair, and removed the mechanical lift from the room;-Without removing his/her soiled gloves, CNA G took the resident out of the room. During an interview on 11/25/25 at 4:25 P.M. CNA G said gloves should be changed and hands washed when care was