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	02/17/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to receive written notice of a room change and ensure residents had the right to share a room with his/her roommate of choice for four residents (Resident #2, Resident #3, Resident #5 and Resident #8) in a sample of 10 residents. The facility initiated room changes for all four residents without providing the resident, family and/or resident representative an explanation in writing of why the move was required. The facility failed to ensure the residents were provided the opportunity to see the new location, meet the new roommate and ask questions about the move. The facility census was 126. Review of the undated facility policy for Room Change/Roommate Assignment showed the following:-Changes in room or roommate assignment are made when the facility deems it necessary or when the resident requests the change;-Resident room or roommate assignment may change if the facility deems it necessary. Resident preferences are considered when such changes are proposed;-Residents have the right to share a room with their roommate of choice, including a spouse, domestic partner, or friend;-Prior to changing a room or roommate assignment all parties involved in the change/assignment are given a verbal or written notice of such change;-Written notice of a roommate change includes why the change is being made and any information that will assist the roommate in becoming acquainted with his or her new roommate;-Residents have the right to refuse to move to another room in the facility unless necessary for health or safety reasons;-If a resident exercises his or her right to refuse a room change, this will not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits. 1. Review of Resident #3's face sheet showed the resident admitted to the facility on [DATE] to a private room. Review of the resident's quarterly MDS dated [DATE] showed the following:-Able to make self-understood and able to understand others;-BIMS (Brief Interview for Mental Status, a standardized, tool with a 0-15 point scale used to screen for cognitive impairment) of 15 (cognitively intact);-Dependent upon staff for Activities of Daily Living (ADL's);-Diagnoses of traumatic spinal cord dysfunction, quadriplegia (paralysis of all four extremities), anxiety and depression. Review of the resident's progress note dated 02/05/26 at 2:14 P.M., signed by Assistant Director of Nursing (ADON) C showed the following:-Social Worker (SW) and this ADON called resident's Power of Attorney (POA) regarding room move. POA was agreeable and understood room move. Resident will be moved from a private room to a shared room. POA questions were all answered at this time and new room number provided. Resident was then made aware by this ADON and SW that he/she will be moving to a shared room tomorrow (semiprivate). Resident had no questions at this time. During an interview on 02/13/26 at 10:45 A.M. the resident said the following:-He/She was very upset over the room move from his/her private room that he/she had for many years to a room that was shared with someone;-He/She was not given an option, the SW and ADON came into his/her room and told him/her that he/she was moving the next day;-Staff came in the next morning and moved him/her to this room;-His/Her family had to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2026

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	take a lot of his/her decorations and belongings home due to no room to place items;-Staff just shoved his/her stuff into boxes and they had not offered to put them away. Observation on 02/13/26 at 10:45 A.M., showed the resident was visibly upset and angry as he/she was talking about the room move and the way staff moved his/her belongings. During an interview on 02/18/26 at 10:00 A.M. Family Member (FM) C said the following:-He/She was POA for Resident #3;-He/She received an email from SW A the day before staff moved the resident that Resident #3 was going to be moved to make room for potential isolation patients and staff knew the resident was going to be upset;-The resident has been in the private room for over two years;-There was no choice of rooms given and no one told him/her or the resident they could refuse the room move. Staff came in and shoved the resident's belongings into boxes and drawers;-The resident was afraid if he/she said anything then he/she would be discharged from the facility;-He/She was also afraid of saying anything in fear of the resident being discharged . 2. Review of Resident #2's face sheet showed the resident admitted to the facility on [DATE] to a private room. Review of the resident's progress note dated 2/9/26 at 11:03 A.M., signed by SW A showed the following:- SW A called and spoke with FM A and FM B about a room change. Consent obtained. (The note did not show what the consent was for) SW will continue to remain involved and assist as needed. Review of the resident's quarterly MDS dated [DATE] showed the following:-Able to make self-understood and able to understand others;-BIMs of 7 (cognitive impairment);-Required assistance of staff for ADL's;-Diagnoses of heart disease, high blood pressure, diabetes and stroke. During an interview on 02/17/26 at 12:40 P.M. FM A and FM B said the following:-They received a phone call on 02/09/26 from SW A telling then the resident would be moved to another room due to the need for a room to quarantine potential residents from the hospital. The room move had been approved by the Administrator;-SW A told them they had three days to move the resident to the other room;-They were not offered any other rooms and were not introduced to the new roommate until the resident moved into the semi-private room. 3. Review of Resident #5's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly MDS dated [DATE] showed the following:-Able make self-understood and able to understand others.-BIMS of 8 (cognitive impairment);-Requires assistance with ADL's;-Diagnoses of heart failure, hypertension, heart disease, fractured hip and dementia. Review of the resident's progress note dated 02/09/26 at 10:09 A.M., signed by SW A showed she called and spoke with resident's family member and obtained verbal consent; (the note did not show what the verbal consent was for); SW will continue to remain involved and assist as needed. Review of the resident's progress note dated 02/10/26 at 11:51 A.M., signed by SW A showed LATE ENTRY SW obtained consent for resident by spouse to move from rehab hall to long term care room that became available. During an interview on 2/19/25 at 2:20 P.M. FM D said the following:-He/She received a phone call from SW A they were moving the resident to a different room. The facility had a new administrator who was changing things and moving residents. He/She asked the SW if this could wait awhile and was told no;-He/She spoke staff who identified himself as the Administrator about moving the resident, and was told the room the resident was in, and had been in since admission, was meant for rehab. The resident was moving to the long term care section of the facility today and the resident was not the only resident who had to move;-The resident was not given the choice of a room or the roommate;-Staff moved the resident the next day. 4. Review of Resident #8's face sheet showed the resident admitted to the facility on [DATE] to a private room with the diagnoses of Hereditary motor and sensory neuropathy (genetic leading to muscle weakness, atrophy, and sensory loss in the feet, legs, and hands), high blood pressure, depression. Review of the resident's quarterly MDS dated [DATE] showed the following:-Able to make self-understood and able to understand others;-BIMS of 13 - able to make (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decisions;-Dependent upon staff for ADL's. During an interview on 02/20/25 at 12:30 P.M. FM E said the following:-He/She received a phone call from a person who identified himself as the Administrator. The Administrator said they were moving the resident to another room due to needing an isolation room for potential COVID patients (a highly contagious respiratory illness caused by the SARS-CoV-2 virus);-He/She spoke with SW A and said this was an infringement on the resident's rights. SW A said they had to move the resident, and the resident's new roommate did not want the camera in the room;-The resident was not offered a choice of rooms to be moved to, nor was the resident introduced to his/her new roommate. During an interview on 02/13/26 at 11:30 A.M. SW A said the following:-She was told by the staff member who identified himself as the Administrator, that residents needed to be moved off the rehab unit and free up those rooms for potential rehab residents. She was to find the residents a room on the long term care side of the facility or to discharge the residents;-She was not aware residents had a choice to move or not, or that they had a choice of roommates;-She was just doing what he/she was told to do;-The Ombudsman was in the facility on 02/12/26 and informed them of what residents' rights were regarding room moves. During an interview on 02/17/26 at 3:00 P.M. the Administrator (identified by SW A as administrator) said the following:-He came to the facility as the Administrator a couple of weeks ago, but his temporary license has not been approved;-He needed to move residents for better acuity for staffing purposes, to keep the rehab residents together and the long term care residents together;-They received permission for the residents to move. During an interview on 02/17/26 at 3:10 P.M. Administrator A said the following:-The facility was trying to streamline things making the acuity more equal among the staff;-He was not aware residents had to right to decline a room move;-He would expect staff to give the resident a choice when able if a room move needed to occur. 2741620

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure three residents (Resident #1, #4 and #7) of 10 sampled residents received appropriate notice of discharge. The facility census was 126. Review of the undated facility policy for Transfer or Discharge showed the following:-Once admitted to the facility, residents have the right to remain in the facility. Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record;-When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: the basis of the transfer or discharge; the appropriate notice was provided to the resident and /or legal representative; the date and time of the transfer or discharge, the new location of the resident, the mode of transportation, a summary of the resident's overall medical, physical and mental condition, disposition of personal effects, disposition of medications. The basis for the transfer or discharge;-Transfer or Discharge Appeals: residents have the right to appeal a transfer or discharge through the state agency that handles appeals;-Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge including the name, address, email and telephone number of the entity which receives such request, information about how to obtain, complete and submit an appeal form, how to get assistance completing the appeal process and the facility bed-hold policy. Review of Residents Rights provided from the Ombudsman program showed the following:-Rights during discharge/transfer: the resident has the right to appeal.-The resident has the right to receive a 30-day written notice of discharge that includes the reason, the effective date, the location of the accepting facility, the appeal rights and process for filing an appeal, and the name and contact information for the long-term care ombudsman. 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 01/27/26 showed the following:-Able to understand others and able to make self-understood;-Cognitively intact;-Dependent upon staff for Activities of Daily Living (ADL's). Review of the resident's progress notes dated 02/10/26 at 2:37 P.M. showed the following:-LATE ENTRY- Power of Attorney (POA) and resident offered placement in a semi-private room on long term care (LTC). Concerns r/t the size and set up of the semi-privaterooms on LTC were expressed due to residents' size and preferences;-Option to transfer to a facility with rooms to better accommodate resident's preferences offered;-POA and resident accepted. All questions answered at that time. Social Worker (S) notified of residents wish to transfer. Review of the resident's progress note dated 02/10/26 at 6:44 P.M. signed by SW A showed she obtained consent for Skilled Nursing Facility (SNF)-to-SNF transfer. Referral sent to facility per family request. Will wait for decision and update family. Review of the resident's progress notes dated 02/11/26 at 2:18 P.M. showed resident discharging to another facility, all belongings packed up and given to driver for new facility. During an interview on 02/26/26 at 10:20 A.M. the Family Member (FM) F said the following:-He/She received a telephone call from SW A on 02/09/26 telling him/her the resident needed to be out of the facility by 02/13/26 due to a reconstruction of the rehab unit and the need to have just rehab residents on the unit;-Neither he/she or the resident were offered a different room or a choice of facilities;-He/She was told that the facility where the resident was discharged had a bed available;-He/She did not know what to do, did not have a chance to see the new facility, and was not aware of any resident rights;-The resident moved to the new facility on 02/11/26.-Neither he/she or the resident received a (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	written notice of discharge. 2. Review of Resident #4's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly MDS dated [DATE] showed the following:-The resident can make self-understood and able to understand others;-Cognition intact;-Dependent upon staff for ADL's. Review of the resident's progress notes dated 02/10/26 at 7:16 P.M. signed by SW A showed the following:-LATE ENTRY SW obtained consent for SNF-to-SNF transfer from resident;- Referral sent to a facility per family request. SW will wait for decision and update family. Review of the resident's progress notes dated 02/11/26 at 9:54 P.M. showed the resident discharged to a sister facility. During an interview on 02/26/26 at 11:00 A.M. the resident's FM G said the following:-He/She received a telephone call from the facility saying the resident had given his/her permission to be moved to a different facility and needed to be out in two days;-The facility told him/her they were reconfiguring the facility so the room that the resident was in was just for rehab residents;-They were not given the opportunity to pack up the resident's belongings, all his/her things were shoved in boxes.-The resident did not receive a written notice of discharge. During an interview on 02/26/26 at 12:15 P.M. FM H said the following:-He/She received a telephone call on 02/10/26 telling him/her the resident had consented to move to another facility because the facility was turning the resident's room back to a rehab room for potential rehab residents;-He/She talked with the resident who did give permission to be moved, but the resident felt like he/she did not have a choice;-No one informed them of their rights to appeal the move;-The resident was having a difficult time at the new facility due to the equipment that was required to take care of him/her;-There was no communication from the facility to the new facility regarding the resident's medication and his/her pain management;-The resident did not receive a written notice of discharge 3. Review of Resident #7's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's comprehensive MDS dated [DATE] showed the following:-Able to make self-understood and able to understand others;-Cognitively impaired;-Dependent upon staff for ADL's. Review of the resident's progress notes dated 02/12/26 at 2:32 P.M. showed the resident discharged to another facility. Review of the resident's progress notes dated 02/12/26 at 2:33 P.M. showed the resident's power of attorney (POA) called and informed of the resident's discharge. During an interview on 02/18/26 at 2:07 P.M. FM I (the resident 's POA) and J said the following:-They received a telephone call on 02/10/26 telling them that the resident had be discharged in two days to a facility they had never heard of;-They called another facility that they knew of, and asked them if they had a bed available for the resident;-The resident moved on 02/12/26, as they did not feel they had a choice;-They were told that they had to make room for an emergency admission;-They nor the resident received a written discharge notice. During an interview on 02/13/26 at 11:00 A.M. SW A and SW B said the following:-They were told around 02/9/26 by Employee A (who they understood was the administrator), they needed to move residents to free up rooms for actual rehab residents. They were to either find a bed on the long-term care side of the facility or discharge the residents;-All the LTC beds were taken, so they had to begin discharging residents to other facilities;-They thought since the facility was transferring resident to another skilled facility, they did not have to issue discharge letters;-They did not issue any 30 day or emergency discharge notices; -The local Ombudsman came to the facility on [DATE] and informed them they had to provide residents a discharge notice, and inform them of their rights;-The Ombudsman went room to room and provided residents a copy of their rights. During an interview on 02/17/26 at 3:00 P.M. Employee A (identified by SW A as the administrator) said the following:-He came to the facility as the administrator a couple of weeks ago, but his temporary license has not been approved;-He needed to move residents for better acuity for staffing purposes, to keep the rehab residents together and the long (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	term care residents together;-They received permission for the residents to be discharged , so they did not need to issue a written discharge notice. 2741164

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff transferred one dependent resident (Resident #10) of ten sampled residents, with a mechanical lift in a safe manner. Instead of lowering the resident slowly to the bed, staff chose to use the lift's emergency release button and dropped the resident quickly to the bed, startling the resident. The facility census was 126.Review of the undated facility policy for Using a Mechanical Lifting Machine showed the following:-The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instruction;-At least two nursing assistants are needed to safely move a resident with a mechanical lift;-Select a sling that is appropriate for the resident's size and the task;-Make sure the battery is charged;-Make sure the lift is stable and locked;-Place the sling under the resident and lower the sling bar closer to the resident;-Attach the sling straps to the sling bar;-Lift the resident two inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution;-Slowly lift the resident. Only lift as high as necessary to complete the transfer;-Gently support the resident as he or she is moved;-When the transfer destination is reached, slowly lower the resident to the receiving surface;-Once the resident's weight is released, stop the lowering and ensure that the sling bar does not hit the resident;-Detach the sling from the lift;-Carefully remove the sling from under the resident. Be mindful of the resident's position and balance, and skin. Review of Resident #10's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a chronic, progressive neurodegenerative disorder that impairs movement and motor control), Alzheimer's disease, dementia and anxiety. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 12/29/25 showed the following:-Usually able to understand others;-Severe cognitive impairment;-Dependent upon staff for transfers. Review of the ring video camera in the resident's room dated 02/12/26 at 1:07 P.M. showed the following:-Certified Nurse Aide (CNA) D and CNA E placed the resident is a mechanical lift sling to transfer him/her from the wheelchair to the bed;-CNA D worked the lift controls and moved the resident in the lift over the bed. CNA D had his/her hands on the resident in the sling during the process;-The resident was over the bed and suspended in the lift when CNA D said, Drop him/her? while he/she had his/her hand at the base of the lift on the red emergency release button;-He/She pushed the emergency release button, and the resident quickly dropped onto the bed. The resident said Oh! At the time the resident dropped to the mattress the bed moved;-The resident said, You said drop it, CNA D said, No you said drop it, the resident then said, why would I say drop it?. During an interview on 02/13/26 at 12:05 P.M. Family Member (FM) K said the following:-He/She showed the video to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) yesterday;-He/She told the DON the way staff lowered the resident to the bed was unacceptable and uncalled for. During an interview on 02/13/26 at 12:30 P.M. the DON said the following:-Resident #10's FM came in yesterday and showed she and the ADON the video of CNA D and CNA E transferring the resident from the wheelchair to the bed;-There was no reason for staff to have used the emergency release button. The mechanical lift battery was charged and there had been no report of the lift malfunctioning. During interview on 02/17/26 at 10:42 A.M. CNA E said the following:-He/She transferred the resident using the mechanical lift one day last week;-CNA D was manning the controls, he/she was guiding the resident;-He/She never head CNA D say, drop him/her. During an interview on 02/17/26 at 1:18 P.M. CNA D said the following:-He/She worked last week and took care of the resident;-He/She used the emergency release button to lower (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident because that lift lowered residents very slow, and the emergency release button lowered them quicker;-He/She had never been told not to use the emergency release button for a transfer;-He/She did not say drop him/her;-The resident said whoa when transferred to the bed. During an interview on 02/17/26 at 3:00 P.M. the ADON said the following:-CNA D admitted using the emergency release button on the lift to lower the resident on the bed;-CNA D has been trained that the emergency release button should only be used in an emergency. During an interview won 01/27/26 at 3:30 Administer A said the following:-The emergency release button should only be used in a real emergency when the resident needed to get out of the lift quickly;-He would expect staff be properly trained on how to use a mechanical lift. 272475