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	04/02/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions as recommended by the registered dietician and ordered by the physician to prevent weight loss and failed to provide meal encouragement for two residents (Resident #1 and #2), who had a significant weight loss. The facility census was 120. Review of the facility policy for Weight Assessment and Intervention, revised March 2022, showed the following:-The threshold for significant unplanned and undesired weight loss will be based on the following criteria: one month - 5% weight loss is significant and greater than 5% is severe; three months - 7.5% weight loss is significant and greater than 7.5% is severe; six months - 10% % weight loss is significant and greater than 10% is severe;-Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met;-The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example: cognitive or functional decline, chewing or swallowing abnormalities, pain, medication-related adverse consequences, environmental factors (such as noise or distractions related to dining), poor digestion or absorption, fluid and nutrient loss and inadequate availability of food or fluids;-Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietician, the consultant pharmacist and the resident or the resident's legal surrogate;-Individualized care plans shall address the identified causes of weight loss are based on careful consideration of the following: resident choice and preferences, nutrition and hydration needs of the resident, functional factors that may inhibit independent eating; the use of supplements.1. Review of Resident #1's care plan for weight, dated 06/13/25, showed the following:-The resident had a diet order of fortified food (products that have vitamins, minerals, or other micronutrients added to them that are not naturally present or are present in small amounts), regular diet, regular texture;-Interventions: Provide diet as ordered. Registered Dietician (RD) to evaluate and treat as needed. Review of the resident' quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/29/25, showed the following:-Severe cognitive impairment;-Required set-up assistance with meals;-Weight 123 pounds. Review of the resident's weights documented in the Electronic Medical Record (EMR), dated 01/06/26 at 5:06 P.M., showed the resident weighed 124 pounds. Review of the Physician Order Sheet (POS) dated February 2026 showed an order for fortified foods, regular texture, and thin liquids. Review of the resident's weights documented in the EMR, dated 02/05/26 at 6:26 P.M., showed the resident weighed 115.4 pounds (a 6.9% weight loss in one month). Review of the RD's progress note, dated 02/13/26 at 2:55 P.M., signed by RD, showed the resident was on a fortified diet. His/Her intake varied and were documented at 0-100%. Per Assistant Director of Nursing (ADON), the resident did not eat well. Current weight was 115.4 pounds, which reflected a 7% weight loss in 30 days, and an 8.4% weight loss in 90 days. Per the ADON, the resident did not like the food. Weekly weights for four weeks was added to monitor weight trends. Review of the resident's weights in the EMR showed the following:-No documentation of a weekly weight during the week of 2/15/26-2/21/26;-On 02/26/26 at 6:35 P.M., the resident weighed 113.6 pounds;-On 03/05/26 at 3:31 P.M., the resident (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weighed 106.2 pounds (a 6.5% weight loss in one week). Review of the resident's dietary progress note, dated 03/08/26 at 11:32 P.M., signed by the Dietary Manager (DM), showed the resident was alert and verbal and able to make his/her needs known. The resident was on a fortified diet. The resident had no noted difficulties with current diet. The resident's appetite was fair/poor. Current weight was noted as a significant weight loss. Interventions were in place for weight loss. (Review of the resident's care plan, dated 06/13/25, showed the only listed intervention for weight loss was a fortified diet.) Review of the resident's dietary progress note, dated 03/13/26 at 1:50 P.M., signed by the RD, showed the resident was on a fortified diet. The resident's intake varied and were documented at 0-100%. Per the ADON, the resident would not sit and eat. He/She liked to roam. Current weight was 106.2 pounds, which reflected a 7.9% weight loss in 30 days. Discussed adding finger foods since he/she roamed while he/she ate. Review of the resident's physician's orders, dated 03/13/26, showed a new order for finger foods. Review of the resident's quarterly MDS, dated [DATE], showed the following:-The resident weighed 106 pounds with an unplanned weight loss of 5% weight loss in two months or 10% weight loss in six months;-Set up assistance required with meals. Review of the resident's care plan for weight, revised 03/31/26, showed no updates to address the resident's weight loss or the RD's recommendation and new order for finger foods. Review of the resident's physician order sheet (POS), dated April 2026, showed an order for fortified foods, regular diet, regular texture, and finger foods. Review of the spreadsheet menu for the dinner meal on 04/01/26 showed the following:-The menu for regular diet included fish and chips with creamy coleslaw, Hawaiian roll and tropical fruit cup;-The menu for finger foods included options of chicken tenders, French fries, a sandwich cut into four, hotdogs, and onion rings;-The fortified foods were a nutritional shake or fortified honey bun. Observation on 04/01/26 at 4:40 P.M., showed the following:-The resident sat at the dining room table in the Memory Care Unit with a plate of [NAME] pie, a roll and a honey bun;-The resident took the honey bun, wheeled himself/herself out of the dining room and down the hall, then turned around, and came back into the dining room;-Three staff were in the dining room assisting other residents with their meals, and one nurse was at the medication cart passing medications;-The resident sat the half-eaten honey bun on the table then wheeled himself/herself between several tables to the counter where a bin of potato chips, cookies and crackers sat. He/She took out a bag of barbeque potato chips, opened the bag of chips, wheeled himself/herself out of the dining room, and ate from the bag of potato chips;-The resident returned to the dining room after several minutes, placed the partially eaten bag of potato chips on the table and wheeled himself/herself back out of the dining room and down the hall;-Staff removed the resident's uneaten plate of food from the table and placed it on the cart to return to the kitchen;-No staff attempted to encourage the resident to eat the food on the plate or offered the resident anything different to eat. Review of the resident's dietary card on 04/01/26 at 5:10 P.M., showed a diet order of fortified foods. There was no order for finger foods listed on the card and observation showed no finger foods were served per the RD's recommendation. During an interview on 04/01/26 at 5:10 P.M., the DM said the resident usually did not eat well and snacked as he/she propelled himself/herself in the wheelchair. Finger foods had not been served to see if the resident would eat them. Review of the spreadsheet menu for the breakfast meal on 04/02/26 showed the following:-The regular diet included cold cereal, bacon strips, scrambled egg, fresh grapes, and French toast stick;-The finger foods menu did not include any food items for breakfast.-The fortified food list did not include any fortified foods for breakfast. Observation on 04/02/26 at 8:40 A.M., showed the resident was in bed with a plate of food on an over-the-bed table in front of the resident. The plate contained one stick of French toast, two slices of bacon, and one scrambled egg. The silverware was still wrapped in a napkin and the resident was in bed with his/her eyes closed. Observation on 04/02/26 at 9:00 A.M., showed the resident lay in bed with his/her eyes closed. Staff removed the plate of food from the resident's room. The resident did not eat any of the food on his/her tray. Staff did not encourage the resident to eat prior to removing the plate of food from the resident's room. Review of the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spreadsheet menu for the noon meal on 04/02/26 showed the following:-The regular diet menu included stuffed baked pork chop, glazed sweet potatoes, maple Dijon Brussel sprouts, wheat dinner roll, and apple crisp;-The finger foods menu consisted of either chicken tenders, French fries, sandwiches cut in four, hotdogs, or onion rings;-The fortified food was potato salad. Observation on 04/02/26 at 12:19 P.M. showed the resident was in bed. The resident's plate of food sat on an over-the-bed table in front of the resident. The plate contained a pork chop, broccoli, and mashed sweet potatoes. The resident had a cup of fruit and was drinking the liquid of the fruit. Staff had not assisted the resident with set up of the meal. Observation on 04/02/26 at 1:00 P.M., showed the resident was awake in bed. Staff removed the plate of uneaten food from the resident's room. The staff did not encourage the resident to eat or offer the resident anything different to eat prior to taking the food from the resident's room. During an interview on 04/02/26 at 2:00 P.M., the DM said the following:-Staff discussed the resident at the weight loss meeting on 03/13/26, but the RD did not issue any orders for finger foods;-He/She was not aware the resident had an order for finger foods on the POS;-It is the DM's responsibility to ensure new dietary orders are implemented;-The facility did not have any potato salad (on the fortified menu) for the noon meal;-He/She thought the mashed sweet potatoes may have been fortified. During an interview on 04/02/26 at 2:30 P.M., the ADON said the following:-Staff discussed the resident's weight loss at a meeting with the RD on 03/13/26;-Staff tried giving the resident finger food, but the resident wanted the main meal staff served to other residents, so staff stopped providing finger foods after a couple of days;-Staff did not notify the RD when they stopped providing the finger foods, and no other interventions were tried to address the resident's weight loss. During an interview on 04/02/26 at 2:36 P.M., the Director of Nursing DON) said the following:-Staff should monitor the resident and offer foods he/she would eat;-Staff should serve the finger foods diet as ordered. If the resident wanted the main meal, staff should serve it to the resident as well. During an interview on 04/02/26 at 3:32 P.M., the RD said the following:-The resident had a significant weight loss;-He/She, the DM, and the ADON discussed the resident's weight loss in a meeting (date unknown); -He/She recommended adding finger foods as the resident liked to wander at mealtimes;-He/She was not aware staff did not offer the resident finger foods;-He/She expected staff to offer finger foods and give the resident the main meal if the resident wanted it as well;-He/She expected staff to notify him/her if a resident refused the recommendations he/she made. 2. Review of Resident #2's face sheet showed the resident's diagnoses included dysphagia (difficulty swallowing, often caused by nerve/muscle issues, strokes, or esophageal obstructions.). Review of the resident's comprehensive MDS, dated [DATE], showed the following:-Able to make self-understood and understood others;-Severe cognitive impairment; -Required supervision with eating. Review of the resident's weights documented in the EMR for January 2026 showed the following:-On 01/13/26, the resident weighed 127 pounds;-On 01/14/26, the resident weighed 119 pounds;-On 01/15/26, the resident weighed 120 pounds;-On 01/16/26, the resident weighed 122 pounds;-On 01/22/26, the resident weighed 116 pounds;-On 01/29/26, the resident weighed 116.8 pounds;-On 01/31/26, the resident weighed 116.8 pound. Review of the resident's weights documented in the EMR, dated 2/5/26 at 2:05 P.M., showed the resident weighed 118.8 pounds. Review of the resident's RD progress note, dated 02/20/26 at 12:14 P.M., showed the resident is now on a fortified diet with a mechanical soft texture with chopped meats. He/She was on a regular diet with a mechanical soft/chopped meats texture before the review today. Intakes are documented at 51-100%. Able to feed self. Current weight is 118.8 pounds, which reflects a 6.4% weight loss in 30 days. RD recommended fortified diet due to weight loss, and the diet order was changed to fortified foods today. Review of the POS for February showed an order for soft/chopped meat and fortified foods with an order date of 02/20/26. Review of the resident's care plan for malnutrition, dated 02/22/26, showed the following:-Focus: Malnutrition: The resident is at risk for malnutrition due to dysphagia and unplanned significant weight loss;-Goal: Will maintain adequate nutritional status as evidenced by stable weight.-Interventions: Allow adequate time for meal (continued on next page)

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