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	06/10/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to follow physician orders for one resident (Resident #1), in a review of eight sampled residents. Staff failed to apply dressings and wraps to the resident's wound on both lower legs and a dressing to the left palm as ordered by the physician. The facility census was 117. Review of the facility policy, Medication and Treatment Orders, revised 07/2016, showed the following:-Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state;-Drugs and biological orders must be recorded on the physician's order sheet in the resident's chart. 1. Review of Resident #1's Physician Order Sheet (POS), dated 06/2026, showed the following:-Apply Ace wrap to right leg only in the morning and remove at night for edema (original order dated 05/10/26);-Wound to left palm: Cleanse with normal saline, apply betadine and dry dressing, and roll in left hand every day shift for wound (original order dated 04/21/26);-Wounds to both lower extremities (BLE): Cleanse with normal saline and pat dry. Apply calcium alginate (a highly absorbent, biodegradable wound dressing used for moderate to heavily draining wounds) to open areas, followed by abdominal dressing (ABD, a thick absorbent dressing) pad. Wrap with kerlix followed by ace wrap every shift every Monday, Wednesday, Friday and as needed for wound (original order dated 06/08/26). Observation on 06/09/26 at 9:45 A.M. showed the resident lay in bed with his/her lower legs uncovered. The resident had open sores on both lower legs. The resident did not have any dressings or ace wraps on his/her legs as ordered. Observation on 06/09/26 at 11:00 A.M. showed the resident lay in bed with his/her lower legs uncovered. The resident had open sores on both lower legs. The resident did not have any dressings or ace wraps on his/her legs as ordered. Observation on 06/09/26 at 1:10 P.M. showed the resident lay in bed with his/her lower legs uncovered. The resident had open sores on both lower legs. The resident did not have any dressings or ace wraps on his/her legs as ordered. Observation on 06/09/26 at 4:35 P.M. showed the resident sat on the side of the bed. The resident had several open wounds on his/her legs that had clear to red drainage. The resident did not have any dressings on his/her lower legs. The sheets on the resident's bed had spots of reddish, dried drainage. The resident did not have a dressing on his/her left palm. The nail of the resident's middle finger dug into the palm of his/her hand. During an interview on 06/09/26 at 4:35 P.M., the resident's family member, Family Member A, said staff were to wrap the resident's legs with a dressing due to the open sores. The resident's left hand was contracted. The resident used to have a splint in the palm of his/her hand, but he/she did not know what happened to the splint. Observation on 06/10/26 at 9:15 A.M. showed the resident sat in a wheelchair in the dining room. The resident did not have any dressings or ace wraps on his/her legs as ordered. The resident did not have a dressing on his/her left palm as ordered. During an interview on 06/10/26 12:02 P.M., Licensed Practical Nurse (LPN) A said the resident was to have a dressing to both lower legs due to open, draining sores. He/She was not aware the resident did not have dressings on his/her lower legs. The resident's left hand was very contracted, and the nail of the resident's middle finger left a sore in the resident's palm. The resident was supposed to have a dressing on his/her left palm. He/She was not aware there was no dressing on the resident's left palm. During an interview on 06/10/26 at 3:30 P.M., the Director of Nursing (DON) said she expected the nurses to follow physician (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. The resident should have dressings on both lower legs and to the palm of his/her hand as ordered. 30225773027618

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide two residents (Residents #1 and #3), who required staff assistance for activities of daily living (ADLs), in a review of eight sampled residents, the necessary care to maintain good personal hygiene. The facility census was 117. Review of the facility policy, Activities of Daily Living (ADL) Support, revised 03/2018, showed the following:-Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs;-Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene;-Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, to include support with hygiene (bathing, dressing, grooming and oral care) and elimination (toileting). Review of the facility policy, Care of Fingernails/Toenails, revised 10/2010, showed the following:-The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections;-Nail care includes daily cleaning and regular trimming. 1. Review of Resident #1's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 05/27/26, showed the following:-Able to make self-understood and able to understand others;-Required staff assistance with dressing and personal hygiene. Review of the resident's Care Plan, dated 05/29/26, showed the following:-The resident required assistance related to anticipated declines in condition due to disease process, cognitive impairment, fluctuating ADLsand weakness-The resident required assistance from one staff for care during the morning and evening. Observation on 06/09/26 at 4:35 P.M. showed the resident's pants and shirt were dirty. The fingers on the resident's left hand were contracted. The fingernail on the resident's middle fingernail was long and pressed into the palm of the resident's hand causing a sore in the palm of his/her hand. There was a musty odor coming from the palm of the resident's hand. The fingernails on both of the resident's hands were long with a dark black substance under the nails. During an interview on 06/09/26 at 4:35 P.M., the resident's family member said the following:-The resident wore the same pants and shirt he/she put on the resident the day prior;-He/She cut the resident's fingernails to keep them from digging into the resident's palm. 2. Review of Resident #3's Care Plan, dated 10/24/24, showed the following:-The resident was incontinent of bowel and bladder;-Staff to anticipate and meet the resident's needs. Encourage the resident to use his/her call light for assistance;-The resident was incontinent of bowel and bladder;-The resident required assistance from one staff for toileting and hygiene;-Staff to provide peri-care with rounds and as needed. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Able to make self understood and able to understand others;-Alert and oriented with some difficulty making decisions;-Required assistance of staff with ADLs;-Incontinent of bowel and bladder. Observation on 06/09/26 at 9:39 A.M. showed the resident lay in bed. There was a foul smelling odor coming from the resident. Observation on 06/09/26 at 9:39 A.M. showed the resident activated his/her call light. Observation on 06/09/26 at 9:59 A.M., Certified Nurse Aide (CNA) E entered the resident's room and a few seconds later exited the resident's room. CNA E turned off the resident's call light. During an interview on 06/09/26 at 10:00 A.M., CNA E said the resident forgot what he/she wanted. Observation on 06/09/26 at 10:01 A.M. showed a foul-smelling odor coming from the resident and the resident's room. During an interview on 06/09/26 at 10:01 A.M., the resident said CNA E never asked him/her why his/her call light was on. CNA E just shut off the call light. Observation on 06/09/26 at 10:30 A.M. showed Licensed Practical Nurse (LPN) F entered the resident's room, took the resident's vital signs, exited the room and told CNA E the resident needed changed. Observation on 06/09/26 at 10:33 A.M. showed CNA E provided incontinence care for the resident. The resident's incontinence brief was saturated with urine and fecal matter. There was dried fecal matter on the resident's buttocks and thighs. During an interview on 06/09/26 at 10:50 A.M., CNA E said he/she was not aware the resident needed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed. The resident did not say he/she had a bowel movement. He/She did not smell any odors. During an interview on 06/09/26 at 12:00 P.M., LPN F said there were usually only two nurse aides on the Memory Care Unit and one nurse. It was difficult for staff to ensure all the residents received care when they needed the care. Staff should make sure to take residents to the toilet and change them as needed. 3. During an interview on 06/10/26 at 3:30 P.M., the Director of Nursing said the following:-Staff should recognize when a resident had a bowel movement and needed changed. She expected staff to assist residents with incontinence care immediately;-Staff should not turn off call lights without ensuring they met the resident's needs;-Staff should provide daily care to the residents, change their clothes, and ensure they cleaned and trimmed their nails. 30276183022577

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1), in a review of eight sampled residents, received the appropriate treatment and services to increase range of motion and/or to prevent further decrease in range in motion in the resident's left hand. The resident had a contracture (fixed tightening of muscle, tendons, ligaments, or skin preventing normal movement) to his/her left hand which prevented him/her from opening his/her hand. The resident did not receive restorative nursing services for range of motion to the left hand. The facility census was 117. Review of the facility policy, Contracture Management, revised 11/2012, showed the following:-Residents will be assisted to maintain normal joint mobility, prevent complications associated with joint deformity and prevent worsening of existing contractures, unless the resident's cognitive, physical or medical condition is such that contracture formation or decline is unavoidable;-Joint mobility limitations/contractures will be identified on the nursing admission assessment upon admission, the scheduled Minimum Data Set (MDS) assessment and Physical Therapy or Occupational Therapy evaluation forms, as applicable;-Document interventions implemented to meet the resident's immediate needs which may include, but are not limited to pain relief, range of motion (ROM), repositioning for comfort and proper alignment, prevention of skin breakdown, padding or cushioning to prevent skin to skin contact, assistance with activities of daily living (ADLs);-Nurse and/or therapist will complete or revise the plan of care to include current or potential joint mobility limitations/contractures or complications;-Ongoing assessments and monitoring of new or existing joint mobility limitations or contractures will be conducted no less often than quarterly by a licensed nurse during the MDS assessment process with referral to rehab as appropriate. 1. Review of Resident #1's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 05/27/26, showed:-Received no physical therapy or occupational therapy, no restorative nursing and no assistance with splints or braces;-Diagnoses included stroke with hemiparesis on one side (a neurological symptom characterized by mild to severe muscle weakness or partial loss of movement on one side of the body). Review of the resident's Care Plan, dated 05/29/26, showed staff did not develop a care plan to address the resident's range of motion or the contractures in his/her hand. Observation on 06/09/26 at 4:35 P.M. showed the resident sat on the side of the bed. A family member assisted the resident to put on pants. The resident's fingers on the left hand were contracted, and he/she was unable to open his/her left hand. The resident's middle and third finger remained closed into the palm of his/her hand. During an interview on 06/09/26 at 4:35 P.M., Family Member A said he/she tried to open the fingers on the resident's left hand and wash the palm of the resident's hand when he/she visited. The resident's middle fingernail was long and caused a sore in his/her palm. The resident used to have a splint for his/her hand, but staff had not put it on the resident for a long time. During an interview on 06/29/26 at 4:35 P.M., the resident said he/she could not move the fingers on his/her left hand. It hurt when he/she or someone tried to moved his/her fingers. During an interview on 06/10/26 at 12:00 P.M. Certified Nurse Aide (CNA) B said he/she was the Restorative Nursing Aide. The resident was not receiving any range of motion (ROM) or restorative nursing services. He/She was unaware the resident's left hand was so contracted. During an interview on 06/10/26 at 12:02 P.M. Licensed Practical Nurse (LPN) A said the fingers on the resident's left hand were contracted and the middle finger caused a sore in the palm of his/her hand. He/She did not know if the resident had a splint to put in his/her hand or if the resident received restorative nursing services for ROM. During an interview on 06/10/26 at 1:30 P.M., the Director of Therapy said the resident did not receive any restorative nursing services, however, the resident would benefit from restorative nursing services. During an interview on 06/10/26 at 1:35 P.M., Certified Occupational Therapy Assistant (COTA) C said a therapist saw the resident in the past and the resident had a soft splint, but the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was unable to use it because the resident could not open his/her hand. During an interview on 06/10/26 at 1:35 P.M., COTA D said he/she remembered therapy had ordered for the resident to wear a split to protect his/her palm due to the contractures. Observation on 06/10/26 at 1:40 P.M. showed CNA B found a hand splint in a drawer in the resident's nightstand. During an interview on 06/10/26 at 1:40 P.M., CNA B said he/she was unaware the resident had a splint for his/her left hand. During an interview on 06/10/26 at 1:45 P.M., LPN A said he/she was unaware the resident had a splint for his/her left hand. During an interview on 06/10/26 at 3:30 P.M., the Director of Nursing said she expected staff to refer residents to therapy when they noticed there may be a contracture for either therapy or restorative nursing services. She was unaware the resident had a splint or his/her fingers on the left hand had become so contracted. The resident would have benefited from restorative nursing services. The staff should have referred the resident to therapy for evaluation for the contracture.