STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265889	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort St Peters	5101 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 ensure staff administered medications as ordered on admission for two residents (Resident #2 and #9), in a review of 18 sampled residents. The facility census was 77. The facility did not provide a policy related to obtaining newly ordered medications from the pharmacy or procedures to follow when the medications were not available. 1. Review of Resident #2's Face Sheet showed the resident's diagnoses included Type 2 diabetes mellitus, pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus) and coronavirus (COVID; highly contagious respiratory virus). Review of the resident's January 2026 Physician Order Sheet (POS) showed an order for stat (immediate) chest x-ray one time for shortness of breath and hypoxia (low oxygen levels) (ordered 1/13/26). Review of the resident's Progress Notes, dated 1/13/26, showed the following:-Chest x-ray results received and showed pneumonia;-Doxycycline (antibiotic) 100 milligrams (mg) twice a day (BID) for five days;-Augmentin (antibiotic) 500/125 mg daily for five days. Review of the resident's January 2026 POS, dated 1/13/26, showed the following:-Augmentin 500-125 mg, give one tablet one time a day for pneumonia for five days;-Doxycycline hyclate 100 mg, give one tablet two times a day for pneumonia for five days. Review of the resident's January 2026 Medication Administration Record (MAR) showed the order for Augmentin and doxycoycline hyclate was dated 1/13/26 at 4:30 P.M. Review showed no documentation staff administered the Augmentin and doxycycline hyclate on 1/13/26. Review of the facility's emergency medication supply inventory list, undated, showed the following medications available for use:-Augmentin 500/125 mg, quantity of seven.-Doxycycline 100 mg, quantity of four. Review of the resident's Progress Notes, dated 1/13/26, showed no documentation staff notified the resident's physician or the pharmacy when the medications were not available. 2. Review of Resident #9's undated Face Sheet showed the resident's diagnoses included influenza A virus with pneumonia (highly contagious respiratory virus), bacterial pneumonia, chronic obstructive pulmonary disease (COPD; a condition caused by damage to the lung and airway that restricts breathing), acute respiratory failure with hypoxia and hypercapnia (elevated carbon dioxide in the blood), and chronic atrial fibrillation (irregular heart rate). Review of the resident's nurse's notes, dated 2/23/26, showed the resident was admitted to the facility from the hospital. Review of the resident's hospital discharge orders, dated 2/23/26, showed the following: -Atorvastatin (medication used to treat high cholesterol) 80 milligrams (mg) at bedtime. Next dose due at bedtime on 2/23/26;-Eliquis (blood thinning medication) 5 mg two times a day. Next dose due evening 2/23/26;-Metoprolol (blood pressure medication) 25 mg, take 1/2 tab (12.5 mg total) two times a day. Next dose due at bedtime on 2/23/26; -Nystatin suspension (antifungal medication) 100,000 unit/ml, give 5 milliliters (ml) four times a day for antifungal for seven days. Next doses due evening and bedtime on 2/23/26;-Ipratropium-Albuterol (DuoNeb; inhaled medication used to treat bronchospasm) 0.5-2.5 milligrams (mg)/3 milliliters (ml) nebulizer solution, take 3 ml every six hours. Last dose given on 2/23/25 at 7:32 A.M. Next dose: nebulizer every six hours. Review of the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's POS, dated 2/23/26, showed the following:-Atorvastatin calcium 80 mg, give one tablet by mouth at bedtime;-Eliquis 5 mg, give one tablet by mouth two times a day; -Metoprolol tartrate 25 mg, give 12.5 mg by mouth two times a day;-Nystatin mouth/throat suspension (antifungal medication) 100,000 unit/ml, give 5 ml four times a day for antifungal for seven days;-Ipratropium-Albuterol 0.5-2.5 mg/ml, 3 ml inhale four times a day for shortness of breath. During an interview on 2/23/26 at 8:05 P.M., the resident said he/she admitted to the facility at 4:00 P.M. today. Review of the resident's MAR, dated 2/23/26, showed the following:-Staff did not administer atorvastatin 80 mg at bedtime (ordered for bedtime); -Staff did not administer Eliquis 5 mg tablet at bedtime (ordered for morning and bedtime);-Staff did not administer metoprolol tartrate 12.5 mg at bedtime (ordered for morning and bedtime);-Staff did not administer nystatin mouth/throat suspension 100,000 unit/ml at 4:00 P.M. and 8:00 P.M. (ordered for 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M.);-Staff did not administer DuoNeb Solution 0.5-2.5 mg/ml 3 ml at 8:00 P.M. (ordered for 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M.). Review of the facility's emergency medication supply inventory list, undated, showed the following medications available for use: -Eliquis 5 mg, quantity of one;-Metoprolol 25 mg, quantity of three. During an interview on 2/24/26 at 6:20 P.M., the resident said he/she did not get his/her bedtime medications last night because the facility did not have the medications. During interviews on 2/24/26 at 6:00 A.M. and 6:28 A.M., Licensed Practical Nurse (LPN) B said the following:-The pharmacy delivered the resident's medications this morning (2/24/26) before 6:00 A.M.; -He/She did not administer any medications to the resident last night (2/23/26) due to no doses were due;-He/She did not have access to the emergency medication kit;-On 2/24/26, he/she pulled up the discharge paperwork where it showed the medication doses that were given at the hospital and when the next doses were due at the facility;-The hospital probably gave the doses that were due on 2/23/26;-After reviewing the discharge orders (on 2/24/26), the resident's hospital discharge orders showed the resident received a dose of Eliquis at 8:00 A.M. on 2/23/26 and the next dose was due in the evening of 2/23/26; -Eliquis was in the emergency medication kit;-He/She could have administered the Eliquis on 2/23/26. During interviews on 2/24/26 at 10:05 A.M., 10:51 A.M. and 11:10 A.M., LPN A said the following: -The facility had an e-kit staff could utilize for medications that were ordered after hours or for new admissions;-He/She was unsure which medications were in the emergency medication kit;-He/She had access to the emergency medication kit if needed;-The resident did not receive his/her medications last night (02/23/26) because the pharmacy had not delivered the resident's medications to the facility;-The facility was waiting on a nebulizer (a medical device used to turn liquid into a mist for inhalation), so the resident still had not received the DuoNeb medication. Review of the resident's MAR, dated 2/24/26, showed staff had not administered DuoNeb Solution 0.5-2.5 mg/ml, 3 ml at 8:00 A.M. and 12:00 P.M. (ordered for 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00 P.M.). 3. During interviews on 2/24/26 at 2:40 P.M., 3:35 P.M. and 5:10 P.M., the interim Director of Nurses (DON) said the following: -A resident's medications should be available when the resident admitted to the facility, even if the resident admitted in the evening, and staff should administer the medications per the resident's physician orders; -If a medication was not available from the pharmacy on admission, staff should check the emergency medication kit for the medication;-If the medication was not available in the emergency medication supply, staff should contact the resident's physician and the pharmacy; -Staff should document if a medication was not in the emergency medication kit or if a medication was not available for administration per orders;-Central supply maintained a supply of medical equipment, including nebulizers;-Nurses were to get ordered medical equipment from central supply. During an interview on 2/24/26 at 5:10 P.M., the Administrator said he expected the nurses to utilize the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emergency medication kit until the medication arrived from the pharmacy or to notify him. The facility had a backup pharmacy they could utilize if needed. During an interview on 03/09/26 at 10:00 A.M., the Medical Director said the following:-He expected the nurses to utilize the emergency medication kit until the pharmacy delivered the medication to the facility; -If the emergency medication kit did not contain the medication, he expected the facility to utilize the back-up pharmacy until the pharmacy could deliver the medication. -If the medication was not available, the nurses should notify the physician for alternate orders. Complaints 2731434, 2731445, 2733928

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #11) of 18 sampled residents received the necessary care and services including appropriate individualized interventions to prevent the development and identification of a Stage 3 pressure ulcer on the resident's buttock. The facility census was 77.Review of the facility policy for Skin Policy and Procedure dated 3/20 showed the following:-Policy: based on the comprehensive assessment of the resident, facility clinical staff will ensure that the resident who enters the facility without pressure injury will not develop pressure injury unless the resident's clinical condition demonstrates that the condition was unavoidable;-The licensed nurse and interdisciplinary team (IDT) will assess and periodically reassess each resident's risk for developing pressure ulcer and take actions to address any identified risks;-The IDT will create a written plan for the identification of risk for and prevention of pressure ulcers;-Identification and evaluation of risk factors of increased/decreased mobility and decreased functional ability, cognitive impairment, under-nutrition, malnutrition including significant weight loss with mobility/positioning concerns;-The nurse will perform a full-body initial skin assessment to identify if the resident is at risk for a pressure ulcer within 6 hours of admission to the facility and weekly;-The nurse will conduct a full-body skin assessment for each resident weekly to ensure no risks have developed;-Each direct care partner will examine each resident's total body skin with each bathing experience and will report any abnormalities to the nurse using the Skin Sheet;-The nurse will conduct a systemic risk assessment for pressure ulcers using the Braden Scale (is a widely used, evidence-based nursing tool to assess a patient's risk of developing pressure injuries) quarterly;-If the resident is determined to be at risk or has developed any skin integrity abnormalities, the nurse will implement action according to the specific skin issues;-The nurse and the IDT will plan and implement preventative care to avoid complications resulting from a resident's inactivity, incontinence;-The nurse and the Staff Development Clinical Educator will educate staff on how to identify risk for and prevent pressure ulcers. Review of Resident #1's face sheet showed the resident was admitted to the facility on [DATE] with the diagnoses of congestive heart failure (CHF a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently), end stage renal disease (ESRD when the kidneys begin or have stopped filtering toxins and waste from the blood), heart failure, anemia and depression. Review of the resident's medical record on 02/24/26 showed no Braden Scale completed upon admission. Review of the care plan for Risk for alteration of the skin dated 02/12/26 showed the following:-The resident is at risk for alteration of the skin;-The resident will be free from skin impairment;-Apply barrier cream, assist with turning and positioning every two to three hours and provide treatments as ordered. Review of the resident's Physician Order Sheet (POS) showed an order for barrier cream to affected areas as needed with an order dated of 02/12/26. Review of the resident's medical record showed no documentation staff had applied barrier cream. Review of the resident's admission progress notes dated 02/12/26 showed the following:-Skin normal color and temperature with no open areas;-Superficial skin loss on buttocks. Review of the resident's progress note dated 02/23/26 showed the following:-The resident is at risk for the development of pressure ulcers;-No documentation of any skin impairments. Observation on 02/23/26 at 5:30 P.M. showed the resident sat in a recliner in his/her room with no pressure relieving cushion in the chair. During an interview on 02/23/26 at 5:30 P.M. the resident said the following:-He/She sat in the recliner all the time. He/She will get up to go to the bathroom and transfer into the wheelchair for therapy;-He/She slept in the recliner because he/she was afraid of rolling out of the bed;-He/She will shift his/her (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	body in the recliner, but basically sleeps on his/her back;-His/Her bottom was sore, and it hurt;-He/She told staff; they just put some type of cream back there;-No nurse had looked at the area. Observation on 02/23/26 at 7:30 P.M. showed the resident in the recliner on his/her back with his/her eyes closed. There was no pressure relief cushion in the recliner. Observation on 02/24/26 at 6:00 A.M. showed the resident in the recliner on his/her back with his/her eyes closed. There was no pressure relief cushion in the recliner. Observation on 02/24/26 at 7:10 A.M. showed the following:-Certified Nurse Aide (CNA) E answered the resident's call light;-The resident said he/she needed to use the bathroom;-CNA E assisted the resident to transfer to a wheelchair and pushed the resident into the bathroom;-CNA E assisted the resident to stand and transfer to the toilet;-As the resident sat down on the toilet, he/she winced and said Ouch, that hurt! when; CNA E asked what hurt, the resident replied, my bottom;-CNA E assisted the resident to stand and looked at the residents bottom;-There was an open area on the inner left buttock the size of a quarter; the open area had bloody drainage. The center of the open area was white with red to pink tissue surrounding the white area;-CNA E said he/she had not seen this before and he/she would have to report to the nurse;-The resident said he/she slept in the recliner all night; the area was very sore. During an interview on 02/24/26 at 7:30 P.M. CNA E said he/she had taken care of the resident before, and the resident complained of his/her bottom being sore, but he/she had not seen the open area. Observation on 02/24/26 at 7:16 A.M. showed the following:- Licensed Practical Nurse (LPN) F entered the resident's bathroom to look at the open area;-There was also a superficial open area on the resident's left buttock. During an interview on 02/24/26 at 7:16 A.M. LPN F said the following:-The larger open area was deep with white tissue and some drainage;-The wound had the appearance of a Stage 3 pressure ulcer (full-thickness tissue loss; subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss);-He/She would have to notify the physician for a treatment;-He/She had not been notified prior to today of the open areas. Review of the resident's medical record on 02/24/26 showed no completed skin assessments after the resident's admission assessment on 02/12/26;-There were no skin sheets completed per the facility policy. During an interview on 02/24/26 at 2:00 P.M. the Interim Director of Nursing said the following:-The Braden Scale should be completed within 24 hours of admission;-Weekly skin assessments should be completed and documented in the resident's electronic medical record;-The facility did not have a wound nurse; nurses were responsible for the assessment of the skin and the documentation in the record;-If there was skin impairment, the nurses should notify the physician for an appropriate treatment;-The DON would be responsible for monitoring to ensure that wounds are assessed and had appropriate treatments;-Staff should encourage the resident to sleep in the bed, and if not, staff should provide the resident with a cushion for the recliner as needed. During an interview on 02/24/26 at 5:30 P.M. the Administrator said he would expect nursing staff to identify any skin impairment and notify the physician for treatment orders. During an interview on 03/09/26 at 10:00 A.M. the Medical Director said the following:-He would expect the nurse aides to observe the skin when they provide care to the resident and notify the nurse. He would expect the nurse to inspect the resident's skin and report any concerns to the wound care team for assessment and treatment;-Issues with the resident's skin should be identified immediately for treatment and to prevent complications. 2746473

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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, evaluate and modify interventions to prevent weight loss for one resident (Resident #18) of eighteen sampled residents. The resident experienced a 13.98% weight loss in two months. The census was 77.Review of the facility policy for Weight Change Investigation with a revision date of 05/2023 showed the following:-The weight change investigation will be initiated with the following: a significant weight change of 5% or more in one month, 7.5% or more in three months and/or 10% or more in six months;-Once the weight change investigation is completed, the dietician and the physician will be contacted for interventions;-The interventions will be updated in the resident chart and if appropriate, the resident or resident's representative will be notified of the interventions;-If the resident or resident representative refuses any of the interventions, education regarding rationale for the interventions will be given. If they continue to refuse, documentation of the refusal will occur in the resident chart and the physician will be notified;-The weight change investigation will occur each month until the weight has stabilized;-If based on the resident's condition, weight stability is the most appropriate goal;-If the weight loss is unavoidable based on resident condition and stabilization is unlikely, a physician should document as to why weight loss is medically unavoidable. Review of Resident #18's undated face sheet showed the resident was admitted to the facility on [DATE] with diagnoses of acute respiratory failure, pulmonary edema (a serious, often life-threatening condition caused by excess fluid accumulating in the lungs), congestive heart failure (CHF a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently), diabetes, protein-calorie malnutrition, osteoporosis (a chronic bone disease making bones fragile and highly susceptible to fractures) and osteomyelitis (infection in the bone) of the left ankle and foot. Review of the resident's care plan for nutrition and hydration initiated 12/06/25 showed the following:-The resident has the potential for alterations in nutrition and hydration;-The resident/guest will maintain adequate nutrition and hydration status throughout the review period;-Evaluate any weight changes. Determine percentage changed and follow facility protocol for weight change; -Monitor/record/report to physician as needed any signs or symptoms malnutrition: Emaciation (a state of extreme, dangerous thinness from severe malnutrition, muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in six months; -Obtain and document weights per physician orders and facility protocol;-Registered Dietician to evaluate and make diet change recommendations as needed. Review of the comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 12/10/25 showed the following:-Usually able to make self-understood and usually able to understand others;-Severe cognitive impairment;-Dependent upon staff for Activities of Daily Living (ADL's);-Has one unstageable pressure ulcer (a severe full-thickness wound where the base is completely covered by dead tissue (slough or eschar), making it impossible to determine the true depth or stage);-Weight of 186, height 5 foot 5 inches, no difficulty swallowing, no nutritional approaches, no history of weight loss or weight gain and receives a therapeutic diet.-Dental status not assessed. Review of the resident's weights documented in the electronic medical record (EMR) on 02/24/26 showed the following:-On 12/06/25 a weight of 192 pounds;-On 12/11/25 a weight of 185 pounds;-On 12/13/25 a weight of 185.2 pounds. Review of the resident's Registered Dietician's evaluation note dated 12/16/25 showed the following:-Diet - 2 gram sodium heart healthy diet;-Weight of 185.2 pounds;- Increased nutrient needs related impaired skin integrity; the resident has a large chronic unstageable pressure ulcer to the left heel;- Recommend discontinuing 2 gm, hearth healthy and calorie controlled diet restrictions. Contact physician to see if fluid (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restriction was still necessary;-Recommend: Regular No Added Salt Diet, sugar free beverages, diet condiments; Add 30 ml (milliliters) Pro Heal (a liquid protein supplement) two times (BID) a day; add Juven (a therapeutic nutritional drink powder designed to support wound healing, including pressure ulcers, diabetic foot ulcers, and surgical incisions) BID. Review of the resident's EMR on 02/24/26 showed the following:-No weights documented from 12/14/25 through 01/21/26;-On 01/22/26 a weight of 159.8 pounds. Review of the resident's POS dated January 2026 showed the following:- No Added Salt (NAS) diet regular texture, thin consistency, sugar free beverages and dietcondiments;- Juven oral packet give one packet by mouth two times a day for wound healing;- ProHealth give 30 ml by mouth two times a day for wound healing. Review of the resident's RD evaluation note dated 01/29/26 showed the following:-On 1/22/25 weight of159.8 pounds;-25.4 pound significant weight loss since 12/13/25 (-13.7%). December weight thought to be an error;-Resident sent out to hospital 1/22/26 and readmitted [DATE] with diagnosis of osteomyelitis. Resident on intravenous (IV) antibiotics, reports she is not interested in food. The resident was ten pounds below her usual body weight. Unstageable wound to left heel debrided (dead tissue removed) at hospital. Wound Vac (a non-surgical device that uses negative pressure therapy to accelerate healing for complex, chronic, or infected wounds) ordered;- Continue NAS diet, 2000 ml fluid restriction. Continue 30 ml Pro Heal BID and Juven BID for wound support. Recommend Magic Cup (a high-calorie, protein-rich nutritional supplement dessert) BID at lunch and dinner, (include as 240 ml of dietary fluids). Review of the resident's January POS on 2/24/26 showed no order for Magic Cup. Review of the resident's weights on 02/24/26 showed the following:-No weights from 01/22/26 through 02/22/26;-On 02/23/26 a weight of 163.8 pounds. Review of the resident's February POS on 02/24/26 showed no order for Magic Cup. Review of the resident's care plan for nutrition and hydration on 02/24/26 and dated 12/6/25 showed no interventions for weight loss. Observation on 02/23/26 at 12:30 P.M. showed the following:-The resident was in bed and staff served a lunch tray of a grilled cheese sandwich and a bowl of fruit;-The resident had his/her own teeth;-The resident ate half of the sandwich;-There was no Magic Cup on the meal tray. During an interview on 02/23/26 at 12:30 P.M. Family Member (FM) A said the following:-He/She usually was with the resident at the noon meal;-He/She had never seen staff serve a Magic Cup. Observation on 02/23/26 at 5:03 P.M. showed the following:-The resident was in bed with his/her meal. Staff served meat and mashed potatoes;-There was no Magic Cup served with the meal. During an interview on 02/23/26 at 5:03 P.M. the resident said he/she did not know what a Magic Cup was and when explained it was like an ice cream, he/she replied he/she had not received Magic Cups. During an interview on 02/24/26 at 9:30 A.M. Licensed Practical Nurse (LPN) G said the following:-If the Registered Dietician made any recommendations they would show up in the queuefor orders;-He/She does not see in the resident's record any recommendations for Magic Cups. Observation on 02/24/26 at 12:15 P.M. showed the following:-The resident was in bed with the noon meal tray on an over the bed table. The meal consisted of ground meat, macaroni and cheese and green beans;-There was no Magic Cup on the meal tray. During an interview on 02/24/26 at 1:15 P.M. the Registered Dietician said the following:-He/She comes to the facility on a weekly basis and reviews any new admission's chart and any resident who may be of concern;-He/She does not attend any meetings with the Director of Nursing (DON), the Administrator or the Interdisciplinary Team to discuss any concerns he/she may have;-He/She does make recommendations and will email the report to the Administrator, Director of Nursing, Dietary Manager (DM) and the Care Plan Coordinator;-He/She reviews weights and has noted some discrepancies, but these had not been addressed;-He/She reviewed the resident's chart on 01/29/26 and noted the resident had a significant weight loss and made the recommendation to add a Magic Cup to the lunch and dinner meals;-He/She did not know why (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	these recommendations were not communicated to the physician. During a telephone interview on 03/05/26 at 11:15 A.M. the DM said the following:-The RD comes in weekly and reviews new admission and any other residents of concern;-The RD emails a report to him/her with recommendations;-He/She reviews the emails and if a recommendation is made, then he/she will change the diet card to reflect those recommendations;-The resident did not have Magic Cup in his/her diet order;-He/She must have missed that RD recommendation. During an interview on 02/24/26 at 5:10 P.M. the Interim DON said the following:-She would expect the RD's recommendation be communicated to the physician for approval;-She would expect the DON and DM to be reviewing these recommendations and communicate them to the physician. During an interview on 02/24/26 at 5:10 P.M. the Administrator said he would expect the RD's recommendations to be reviewed and communicated to the physician for approval. During a telephone interview on 03/05/26 at 11:15 A.M. the DM said:-The RD comes in weekly and reviews new admission and any other residents of concern;-The RD emails a report to him/her with recommendations;-He/She reviews the emails and if a recommendation is made, then he/she will change the diet card to reflect those recommendations;-The resident did not have magic cup in his/her diet order;-He/She must have missed that RD recommendation. During an interview on 03/09/26 at 10:00 A.M. the Medical Director said he would expect the nursing staff and the Interdisciplinary Team (IDT) to review and communicate any recommendations from the RD to the physician for residents who have had a weight loss to address the weight loss. 2733928

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	265889	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort St Peters	5101 Executive Centre Parkway Saint Peters, MO 63376

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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 secure medications behind at least one locked door or cabinet when staff left medications unattended on the nurses station and treatment cart and failed to lock treatment and medication carts when unattended. The facility failed to secure medications for one resident (Resident #9), in a review of 18 sampled residents. The facility census was 77. Review of the undated facility policy, Medication Labeling and Storage, showed medications and biologicals in medication rooms, carts, boxes and refrigerators are maintained within secured (locked) locations, accessible only to designated staff. Review of the facility policy, Administration of Medications, revised April 2023, showed to never leave the medication cart open and unattended. 1. Observation on 2/23/26 at 7:35 P.M., showed the following:-Eighteen medication cards were stacked on top of the desk at the nurses station; -Five medication bottles sat unattended on top of the treatment cart at the nurse's station; -The treatment cart was not in use and was in front of the nurse's station counter easily accessible to residents and visitors;-Residents and visitors walked past the nurse's station and treatment cart;-No staff was in the area or in line of sight of the unsecured medications. Observation on 2/23/26 at 7:44 P.M., showed the following:-Eighteen medication cards lay on the desk at the nurse's station;-Five medication bottles sat on top of the treatment cart at the nurse's station;-No staff was in the area or in line of sight of the unsecured medications;-One resident and his/her visitors walked past the unattended medications at the nurse's station. Observation on 2/23/26 at 7:47 P.M., showed Licensed Practical Nurse (LPN) B put the 18 medication cards from the nurse's station desk and the five medications from on top of the treatment cart in the locked medication room. During interview on 2/23/26 at 7:47 P.M., LPN B said the following:-Medications were not to be left unlocked or unattended;-The 18 medication cards on the desk at the nurse's station and the five medications on top of the treatment cart had been there since 6:45 P.M. when the pharmacy delivered them to the facility;-He/She had not had time to put the medications away. Observation on 2/24/26 at 6:15 A.M. showed the following:-The treatment cart, which contained medications, was unlocked at the nurse's station;-No staff was at the nurse's station or in line of sight of the treatment cart. Observation on 2/24/26 at 6:24 A.M., showed the following:-The treatment cart, which contained medications, and the medication cart were unlocked at the nurse's station;-No staff was at the nurse's station or in line of sight of the treatment and medication carts. During interview on 2/24/26 at 6:28 A.M., LPN B, who was responsible for passing medications and completing treatments on the night shift on 2/24/26, said staff were to lock medication and treatment carts when the carts were unattended. Observation on 2/24/26 at 6:36 A.M., Registered Nurse (RN) C locked the medication cart and treatment cart at the nurse's station. During interview on 2/24/26 at 6:40 A.M. and 7:31 A.M., Registered Nurse (RN) C said the following:-Staff should always lock medication and treatment carts when the carts were unattended;-He/She locked the medication and treatment carts at the nurse's station when he/she arrived at the facility (on 2/24/26);-Staff should never leave medications unattended at the nurse's station or on a medication or treatment cart. During an interview on 2/24/26 at 5:10 P.M., the Director of Nursing (DON) said the following:-Staff should lock the medication carts and treatment carts when they left the carts unattended; -Staff was not to leave medications unattended on the counter at the nurse's station;-Staff should secure the medications with a lock when they received the medications from the pharmacy. During an interview on 2/24/26 15 5:10 P.M., the Administrator said he expected staff to lock medication carts and treatment carts when they left them unattended. 2. Review of Resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#9's undated Face Sheet showed the resident's diagnoses included influenza A virus with pneumonia (highly contagious respiratory virus), bacterial pneumonia, chronic obstructive pulmonary disease (COPD; a condition caused by damage to the lung and airway that restricts breathing), and acute respiratory failure with hypoxia (low oxygen) and hypercapnia (elevated carbon dioxide in the blood). Review of the resident's nurse's notes, dated 2/23/26, showed the resident admitted to the facility from the hospital. During an interview on 2/23/26 at 8:05 P.M., the resident said the following:-He/She was admitted to the facility today at 4:00 P.M.;-He/She had inhalers at his/her bedside and self-administered them;-He/She brought the inhalers to the facility from his/her home. During interview on 2/24/26 at 11:10 A.M., Licensed Practical Nurse (LPN) A said the following: -He/She was not aware the resident had prescription inhalers at his/her bedside;-The prescription inhalers were not supposed to be at the bedside without an order to self-administer the medication. Observation on 2/24/26 at 11:00 A.M., showed the following:-Four prescription inhalers lay at the foot of the resident's bed on top of the covers.-The four inhalers included one tiotropium inhaler (inhaled medication to treat chronic obstructive pulmonary disease (COPD) and asthma), one albuterol inhaler (inhaled medication to treat or prevent bronchospasms), and two Arnuity inhalers (inhaled medication to treat asthma). Review of the resident's Physician's Orders, dated February 2026, showed the following: -An order for fluticasone furoate inhalation aerosol powder breath verbal activated 100 mcg, inhale one puff orally one time a day for shortness of breath;-No physician order for tiotropium inhaler and albuterol inhaler; -No physician order to keep medications at the resident's bedside. During interview on 2/24/26 at 5:10 P.M., the interim DON said the following: -Staff had to assess residents prior to residents administering their own medications, and staff had to obtain an order for a resident to self-administer the medications; -She was not aware the resident had inhalers at his/her bedside;-Even if a resident had an order to self-administer, the medications should be kept in a secure location and not on the resident's bed. 3. During an interview on 03/09/26 at 10:00 A.M., the Medical Director said staff should secure all medications behind at least one locked door or drawer. 2731445

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide one resident (Resident #10), in a sample of 18 residents with an evening meal. The resident admitted to the facility on the evening shift and staff provided no meal tray for the resident. The resident's family had to go to a local restaurant and bring food to the resident. The census was 77.The facility did not provide a policy for meal service to new admissions upon request. Review of Resident #10's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of fracture pelvis, respiratory failure and protein-calorie malnutrition. Review of the resident's physician order sheet dated 02/23/26, showed a diet order of a regular diet with mechanical soft foods. Observation and interview on 02/23/26 at 7:27 P.M. showed the following:-The resident and Family Member (FM) B in the resident's room;-FM B said the resident arrived at the facility on 02/23/26 at 5:55 P.M. from a local hospital for therapy due to a fractured pelvis;-No staff offered or brought the resident any food when they first got to the facility, so he/she went to a local restaurant and bought food for the resident;-He/She only saw one staff member that evening, a nurse who told him/her the kitchen was closed for the day. During an interview on 02/24/26 at 7:30 A.M. the resident said:-He/She was waiting for breakfast, and he/she was hungry, he/she did not get a lot to eat for supper last evening;-His/Her daughter had to bring food in for him/her due to not getting a meal tray from the facility. During an interview on 03/05/26 at 11:15 A.M. the Dietary Manager said the following:-He/She is notified via a memo of any admissions that are coming that day;-He/She was not aware ahead of time of specific ordered diets, so he/she must wait for the resident to be in the facility and the nursing staff to enter the resident's information into the Electronic Medical Record (EMR) before he/she can enter their diet information into the dietary system;-If a resident was admitted before 7:00 P.M.; nursing should come to the dietary department and inform the dietary staff the resident is in the facility and nursing staff should ask the resident what they would like to have for the meal;-If nursing staff has not come back to the kitchen and informed them the resident has been admitted , then the dietary department will leave a tray in the window for nursing staff to take to the resident when they arrive at the facility;-On 02/23/26, the dietary department was notified via a memo earlier that day of several admissions arriving and they had made up three or four meal trays. There were not told Resident #10 was in the facility, so they left the tray in the kitchen window for the resident when he/she arrived;-He/She was not aware staff told the resident the kitchen was closed and the family had to purchase food for the resident;-The tray of food was in the kitchen window the next morning and staff had not passed the tray to the resident. This was not the first time this has happened;-Food was available when the resident was admitted , no one came to the kitchen to get the food. During an interview on 02/24/26 at 5:10 P.M. the Director of Nursing and the Administrator said if the resident was admitted after supper, they would expect nursing staff go to the kitchen and get the resident a meal tray. During an interview on 03/09/26 at 10:00 A.M. the Medical Director said he would expect all new admissions or residents who have returned from the hospital late to receive some type of nourishment, either a meal tray, sandwich, or what the resident might want. 2731343

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate infection control measures for two residents (Residents #1 and #11), in a review of 18 sampled residents, when staff did not utilize enhanced barrier precautions (EBP, an infection control strategy in nursing homes that expands the use of personal protective equipment (PPE), specifically gowns and gloves, for high-contact care activities to prevent the spread of multidrug-resistant organisms (MDROs)), as directed in the facility policy. The facility census was 77. Review of the facility policy, Enhanced Barrier Precautions (EBP), dated March 2024, showed the following:-EBP is implemented as an intervention this facility uses to reduce transmission of resistant organisms that employs targeted PPE use during high contact resident care activities;-EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities;-Residents with the following conditions require EBP for all cares and services regardless of MDRO colonization status: -Wounds, including any skin opening requiring a dressing regardless of MDRO colonization status; -Indwelling medical devices regardless of MDRO colonization status, including but not limited to central line, urinary catheter, feeding tube, tracheostomy/ventilator;-Gowns and gloves are used during high-contact activities with increased risk for MDRO transmission to staff clothing and hands including but not limited to: -Dressing; -Bathing/showering; -Transferring; -Providing hygiene; -Changing linen; -Changing briefs or assisting with toileting; -Device care or use including but not limited to central line, urinary catheters, feeding tubes, tracheostomy/ventilator and wound care: any skin opening requiring a dressing;-All staff will be trained and in-serviced and will demonstrate competency at the time of hire, prior to providing direct care to any resident, with any outbreak of infection in the facility, at least annually, and any time a staff member's supervisor identifies a need for additional training;-If a situation occurs requiring implementation of this policy the facility's Infection Preventionist (IP) will immediately complete: -EBP are indicated for residents who are at increased risk of MDRO acquisition such as resident has a wound or indwelling medical device; -Post subtle, dignified, clear signage on the door or wall outside the appropriate room indicating type of precautions and required PPE including gown and gloves; -For EBP, signage will clearly indicate the high-contact care activities that require the use of a gown and gloves; -Make PPE, including gowns and gloves, available near or outside resident's room; -Incorporate periodic monitoring and assessment of adherence to recommended infection prevention practices including hand hygiene and appropriate use of PPE to determine need for additional training and education; -Provide education to staff, residents, family members and visitors with written and verbal educational tools;-Residents will be maintained in EBP throughout the duration of the resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed the resident at higher risk. 1. Review of Resident #11's undated face sheet showed he/she admitted to the facility on [DATE]. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 02/12/26, showed the resident had an indwelling urinary catheter (a tube inserted into the bladder to drain urine). Review of the resident's care plan for Enhanced Barrier Precautions related to the indwelling catheter, dated 02/12/26, showed the following:-Provide EBP as indicated;-Use PPE, specifically gowns and gloves, during high contact resident care activities (i.e., prolonged direct contact). Observation on 02/24/26 at 7:10 A.M. showed the following:-No sign on the resident's door indicating staff should utilize EBP when caring for the resident, and no gowns were available outside or inside the resident's room;-Certified Nurse Assistant (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA) E entered the resident's room. The resident said he/she needed to use the bathroom;-The resident had a urinary catheter;-CNA E, without donning a gown or applying gloves, placed a gait belt around the resident's waist and transferred the resident from the recliner into a wheelchair, placed the urinary catheter collection bag on the side of the wheelchair and pushed the resident into the bathroom;-Once in the bathroom, CNA E put on a pair of gloves, did not put on a gown, placed his/her hands on the gait belt and assisted the resident to a standing position at the toilet;-CNA E pulled down the resident's pants and assisted the resident to sit on the toilet;-CNA E removed the resident's pants and unsoiled incontinence brief, pulled the urinary catheter through the pant leg, and attached it to the handrail;-The resident complained about a sore on his/her bottom;-CNA E removed his/her gloves, and without washing his/her hands, he/she exited the room;-Licensed Practical Nurse (LPN) I and CNA E entered the resident's bathroom, each wore gloves, but neither wore a gown;-CNA E assisted the resident to stand from the toilet;-LPN I wiped the resident's bottom with toilet paper. The resident cried out, Ouch! -LPN I noticed a couple drops of blood on the toilet tissue and said he/she would tell the resident's nurse. LPN I removed his/her gloves and left the room; -LPN F entered the resident's bathroom room wearing gloves, but no gown. LPN I sprayed wound cleanser on gauze and wiped the resident's buttock. Blood was visible on the gauze. LPN F applied a dressing on the open wound, removed his/her gloves, used hand sanitizer, and left the room;-CNA E wiped the resident's bottom with a wet wipe, pulled the catheter tubing through the leg of his/her pants, secured the tubing to the wheelchair, pulled up the resident's pants, transferred the resident back into the wheelchair, and pushed the resident back to the recliner. CNA E transferred the resident from the wheelchair into the recliner;-CNA E removed his/her gloves and used hand sanitizer to cleanse his/her hands before exiting the room. During an interview on 02/24/26 at 7:30 A.M. LPN E said EPB should be used when you put creams on the skin. During an interview on 02/24/26 at 7:45 A.M. CNA E said he/she was not sure what EBP was used for, he/she wore gloves when he/she took care of residents. 2. Review of Resident #1's Face Sheet showed the following:-The resident was admitted on [DATE];-The resident's diagnoses included end stage renal disease and dependence on renal dialysis (a life-sustaining treatment for kidney failure that involves filtering the blood to remove waste and excess fluid). Review of resident's admission MDS, dated [DATE], showed the following:-Occasionally incontinent of urine and always incontinent of bowel;-Dependent on staff for showering/bathing and toileting;-Required partial/moderate assistance with personal hygiene. Review of the resident's Care Plan, dated 02/15/26, showed the following:-The resident was on EBP related to wounds and dialysis central venous catheter (CVC; a tube inserted into a vein for rapid blood access);-Provide EBP as indicated;-Use PPE, specifically gowns and gloves, during high contact resident care activities (prolonged direct contact). Review of the resident's February 2026 Physician Order Sheet (POS), showed the following:-Cleanse gluteal (buttock) wounds with normal saline and apply medi-honey (an antimicrobial wound dressing) with foam dressing every day shift;-Cleanse right heel with normal saline and apply medi-honey with foam dressing every day shift;-Coccyx (tailbone) - cleanse wound with normal saline, apply medi-honey and cover with foam dressing. Change daily and as needed;-EBP for wounds and dialysis CVC;-Dialysis on Monday, Wednesday and Friday;-Monitor dialysis site left upper extremity (LUE) fistula, right chest CVC every Monday, Wednesday and Friday. Review of the resident's wound assessment, dated 2/19/26, showed the following: -Coccyx wound 0.6 centimeters (cm) by 0.4 cm by 0.2 cm;-Left buttock 0.6 cm by 0.6 cm by 0.2 cm;-Right arm 1.4 cm by 1.7 cm by 0.2 cm;-Right heel 0.8 cm by 2.2 cm by 0.4 cm. Observation on 2/23/26 at 10:19 A.M., showed no EBP sign on the resident's door and no PPE cart outside of the resident's room. During an interview on 2/23/26 at 11:03 A.M., CNA D said he/she knew when to wear (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a gown into a resident's room when there was a sign on the door. Observation on 2/23/26 at 3:55 P.M., showed no EBP sign on the resident's door and no PPE cart outside of the resident's room. Observation on 2/23/26 at 4:57 P.M., showed the following:-No EBP sign on the resident's door;-No PPE cart outside of the resident's room.-LPN A and an unidentified staff entered the resident's room and donned gloves. Neither staff put on a gown. Observation and interview on 2/23/26 at 5:02 P.M., showed the resident's guest left the resident's room after staff provided care. The guest said staff only wore gloves when they provided care to the resident. During an interview on 2/24/26 at 7:27 A.M., LPN A said the following:-He/She was not sure if the resident was on EBP;-He/She only wore gloves when he/she provided care to the resident (on 2/23/26). During an interview on 2/24/26 at 7:14 A.M., Registered Nurse (RN) C, a nurse manager, said the following:-Every resident who was on enhanced barrier precautions should have a PPE cart outside the room or PPE door hanger;-Residents with dialysis access and/or wounds should be on EBP;-He/She was not sure if the resident was on EBP;-The resident should be on EBP for dialysis access and wounds;-He/She guessed the EBP sign never got on the resident's room door. Observation on 2/24/26 at 7:22 A.M. showed no EBP sign on the resident's door and no PPE cart outside of the resident's room. During an interview on 2/24/26 at 7:22 A.M., resident's spouse said staff only wore gloves when they provided wound care to the resident. Observation on 2/24/26 at 8:08 A.M., showed the following:-No EBP sign on the resident's door;-No PPE cart outside of the resident room;-Certified Nurse Assistant (CNA) D changed the resident's linens while the resident lay in the bed;-CNA D only wore gloves and did not wear a gown. Observation on 2/24/26 at 9:17 A.M., showed the following:-The resident had an AV fistula (irregular connection between an artery and vein used for hemodialysis) in his/her left arm; -The resident had a central venous catheter (long, flexible tube inserted into a large vein in the neck, chest or groin with the tip resting near the heart to administer medications, fluids or blood products) in his/her upper chest. During an interview on 2/24/26 at 5:10 P.M., the Director of Nursing (DON) said the following:-Staff was to use EBP for any resident who had a history of MDRO, a draining wound, or an indwelling medical device that included catheters, intravenous lines, dialysis access, and central lines;-Nurse managers were responsible for setting up EBP; -She was responsible for ensuring EBP was in place for residents. During an interview on 2/24/26 at 5:10 P.M., the Administrator said he expected staff to know which residents should be on EBP. During an interview on 03/09/26 at 10:00 A.M., the Medical Director said he expected all staff to be knowledgeable regarding Enhanced Barrier Precautions and for staff to utilize all required personal protective equipment.