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	03/10/2026

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow standards of practice for three residents (Resident #1, #2, and #6), when staff failed to complete neurological assessments (to detect brain injury), for two residents (Resident #1and #6) who sustained falls of seven sampled residents. Staff failed to do complete a thorough assessment, provide first aid and stay with Resident #1 following a fall with injury to the head. Staff failed to provide a report to emergency personnel who responded to transport the resident to the hospital. The facility also failed to monitor Resident #2 after the resident experienced a change in condition and developed a blood clot in the leg. The facility failed to provide a report to emergency personnel with pertinent health history information when they were on scene to transport the resident to the hospital. The census was 69. The facility did not provide a policy for resident change of condition or information to report to emergency personnel when emergency services responded to a call at the facility. Review of the facility policy for Neurological assessment dated 09/19 showed the following:-Neurological assessments are done upon physician order when indicated for a change of condition, unwitnessed fall and head injuries;-Observe behavior and note and significant change from normal;-Determine the location and type of any pain;-Determine level of consciousness and responsiveness as compared to baseline;-Determine orientation to person, place and time as compared to baseline;-Determine capability of movement and strength of all extremities as compared to baseline;-Check pupil size and reaction to light;-Note speech to determine if it is clear, rambling, incoherent and absent as compared to baseline;-Check vital signs;-The neurological assessment should be documented on the neurological flow sheet or in the nurses notes;-Any significant change will be reported to the physician. Review of the undated Neurological Flow Sheet showed the following:-Vital Signs and Neuro Checks: every 15 minutes for one hour, then every 30 minutes for one hour then every hour for four hours, then every four hours for 24 hours;-Notify physician IMMEDIATELY of signs and symptoms of intracranial pressure (headache, vomiting (often without nausea), changes in mental status (restlessness, confusion, lethargy), blurred/double vision, and pupil changes). 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of osteomyelitis (infection in the bone) of the left ankle and foot, peripheral vascular disease (PVD-a circulatory disease) and hypertension (high blood pressure). Review of the resident's physician orders for March 2026 showed an order for Eliquis (a prescription blood thinning medication) 2 milligrams (mg) two times a day (BID). Review of the resident's nurses notes dated 03/1/26 at 4:30 P.M. signed by Registered Nurse (RN) C showed the following:-The resident rolled out of his/her bed, reaching for his/her phone charger, landing on the right side of his/her body. Resident found on the floor, on the left side of his/her bed, between the bed and the recliner. The resident had a gash to the right temple, with swelling and reported headache. Vital Signs: Blood pressure (BP) 160/90 (normal 120/80), pulse (P) 110 (normal 60-100), temperature (T) 97.6 (normal 98.6), respirations (R) 24 (normal 12-20). The dressing to the resident's left foot was no longer intact. 911 contacted to take to the emergency room for evaluation. There was no documentation of a neurological assessment. Review of the resident's nurses notes dated 03/1/26 at 7:51 P.M. showed the following:-Resident returned via EMS (Emergency Medical Services) from a (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 - Some	local hospital after a fall during day shift. The resident fell out of the bed and hit his/her head;-CT scan of the head (computed tomography -x-ray images of structures inside the body converted to pictures on a monitor) negative;-Sutures to the forehead intact. Dressing to forehead clean, dry and intact. Vital Signs stable. Denies pain at this time. Safety checks in place. Bed is low. Instructed to report dizziness or light headedness to this nurse;- Physician notified. No new orders. Plan of care ongoing. Review of the resident's comprehensive Minimum Data Set (MDS) dated [DATE] showed the following:-Able to make self-understood and able to understand others;-BIMS (Brief Interview for Mental Status tool used in long-term care settings to assess cognitive function) of 15 indicating intact cognition. During an interview on 03/10/26 at 10:20 A.M. the resident said the following:-He/ was in the facility for some therapy after a stroke;-About a week ago, he/she was reaching for his/her cell phone and fell off the bed hitting his/her head on the chair;-He/She could not find the call light, so he/she tried yelling for help. He/she lay on the floor for a long time before someone came in the room;-When staff came in, they said they could not get him/her off the floor because he/she hit his/her head, and they had to call 911; staff then left the room;-No one came and put anything on his/her head to stop the bleeding. He/She found a pair of pants on the floor and put them on his/her head to stop the bleeding;-After a long time, EMT's came in and took him/her to the hospital. During an interview on 03/11/26 at 5:30 P.M. Emergency Personnel Staff C said the following:-He/She responded to the call for the resident. When he/she entered the resident's room, there was no staff member in the room with the resident. The resident was on the floor and had placed a pair of pants on his/her forehead to stop the bleeding from a laceration he/she sustained from the fall. The resident said no one had come to assess him/her;-He/She left the room to find a staff member, and a staff member pushing a food cart down the hall told him/her where to find the nurse;-He/She located a nurse at the nurses' station completing paperwork. The nurse identified him/herself as Registered Nurse (RN) C and came to the room after EMS had the resident on the gurney. RN C handed them the paperwork and said he/she was going to get an ice pack. RN C left the room without giving them any type of report or providing care to the resident;-He/She was concerned if the resident was on any blood thinners and had received the appropriate care after the fall. During a telephone interview on 03/19/26 at 4:00 P.M. RN C said the following:-He/She was notified by staff members the resident was on the floor, and he/she went into the room and assessed the resident;-He/She did not get the resident off the floor as the resident had a laceration to the head and he/she did not know if the resident had sustained internal injuries;-He/She left the room to notify EMS and complete paperwork and thought the nurse aides were still in the room with the resident. He/She was not aware they had left the room;-He/She must have been at a different nurses station on a different hall completing paperwork and making copies when the EMS personnel came to the nurses station, he/she assumed the nurse aides were in the resident's room;-He/She did not start neuro checks after the resident had fallen because the resident was going to the emergency room;-He/She could not remember if the resident was on any type of blood thinners;-He/She did not apply any pressure to the laceration or give the staff anything to put on the laceration to the resident's head, he/she was focused on sending the resident out to the emergency room;-He/She knew that when a resident falls and it was not witnessed then neuro checks should be done. During an interview on 03/10/26 at 2:40 P.M. the Assistant Director of Nurses (ADON) B said the following:-Resident #1 did not have any neurological assessments completed after the fall on 03/01/26;-Nursing staff should stay with a resident after they had fallen and have injuries until emergency services arrive. 2. Review of Resident #2's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of fractured pelvis, toxic encephalopathy (degenerative brain disease), acute respiratory failure, interstitial pulmonary disease (a chronic disease of the lungs making it difficult to breathe), atrial fibrillation (irregular heart rhythm) and anemia. Review of the resident's physician orders dated 03/01/26 showed and order for apixaban (Eliquis) 2.5 milligrams (mg) two times a day (BID) with a start date of 02/23/26. Review of the resident's care plan for anticoagulant therapy dated 02/24/26 showed the following:-The resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will be free from discomfort or adverse reactions related toanticoagulant use;-Labs as ordered. Report abnormal lab results to the MD; Monitor/document/report as needed adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising , blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Review of the resident's progress notes signed by a Nurse Practitioner dated 03/3/26 showed mild bluish discoloration noted on the dorsum (upper portion of the foot) of both feet, has two pair of socks on each foot. Discussed with family to avoid use of tight socks or double socks as it can place pressure on skin and cause pressure injury.Case discussed with physician who went to see resident today. Physician ordered an ultrasound arterial and venous doppler stat (immediately) results pending. Review of the results of the resident's doppler study dated 03/5/26 at 8:34 A.M. showed the following:-Venous Doppler: There is intraluminal thrombus (a blood clot formed within the lumen of a vessel) in the left saphenous (large vein in the leg), left popliteal (vein located directly behind the left knee joint) , and left peroneal veins (deep veins in the lower leg) with non-compressibility and lack of augmentation (acute deep vein thrombosis (DVT) of the lower extremity, likely with concomitant superficial vein involvement; -Conclusion: Deep vein thrombosis (blood clot) involving the left saphenous, left popliteal, and left peroneal veins.No right deep vein thrombosis). Review of the resident's progress note dated 03/5/26 at 8:36 A.M. showed physician notified of doppler findings. Review of the resident's medical record dated 03/05/26 showed no further documentation regarding the resident's condition, any further physician orders as a result of the doppler study, or a transfer of the resident to the hospital. Review of the resident's Patient Care Report from the local ambulance provider dated 03/05/26 at 9:33 A.M. showed the following:-Dispatched to transfer/Interfacility, responded with lights and sirens (emergent);-Complaint: dyspnea (shortness of breath);-History provided by the family at bedside, facility staff not reporting to room despite the call being initiated as an emergency call. Family reporting noticing deep tissue bruising bilateral lower extremities on 02/26. Arterial/venous doppler performed on 03/03/26 due to bruising found bilaterally to both lower extremities. Results from the doppler were received. Family noticed the resident having increased respiratory effort over the past couple of days. Per family staff reported the resident being fine when asked about his/her respiratory status. Contacted facility staff only after the resident had been assessed, interventions initiated and the resident had been transferred and secured to the stretcher exiting the room, approximately 20 minutes after EMS personnel arrived on seen; -Upon arrival found the resident consistent with the reported baseline information per the family. Resident on 4 liters of oxygen via nasal cannula. The resident noted to have increased work of breathing and see-saw like respirations (an abnormal, paradoxical breathing pattern where the chest sinks in while the abdomen expands during inhalation, and vice versa during exhalation). Has noticeable bruising and tenderness to lower extremities bilaterally;-Resident admitted to the hospital. During an interview on 03/17/26 at9:00 A.M. Emergency Personnel Staff D said the following:-When they arrived on the scene on 03/05/26 there was no staff in the resident's room;-The resident was having some difficulty breathing; they were surprised that no staff was available;-A family member was in the room, who seemed to have medical background and told them about the doppler study and what the physician had said;-They were in the room about 20 minutes, had assessed the resident, transferred the resident to a stretcher, and were leaving the room when a staff member came in and identified themselves as a nurse;-This person did not know what was going on with the resident or that the resident was having some respiratory distress. During an interview on 03/11/26 at 5:11 P.M. Family Member (FM) A and FM B said the following:-They were in the room when the emergency personnel arrived to take the resident to the hospital, there were no staff available for the emergency personnel;-FM B informed emergency personnel of the doppler study and results, the conversation with the physician earlier and why they were called to transport the resident to the hospital;-Emergency personnel had the resident on the stretcher and were about to the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leave the room when RN D arrived;-They had not seen RN D all morning and RN D had not taken care of the resident that day;-When emergency personnel asked about the resident's shortness of breath, RN D told them that this was normal for the resident, RN D did not have all the information about the resident to give to emergency personnel. During an interview on 03/10/26 at 3:30 P.M. LPN D said he/she was not the nurse who sent the resident to the hospital, Registered Nurse (RN) E was the nurse who sent the resident to the hospital During an interview on 03/10/26 at 5:20 P.M. RN E said the following:-He/She was going back to the resident's hall as emergency personnel were leaving the resident's room [ROOM NUMBER]/05/26;-He/She told the resident's nurse he/she would give the emergency personnel report;-He/She told emergency personnel about the doppler study, and that the resident had some pressure ulcers. During an interview on 03/10/26 at 5:00 P.M. the Interim Director of Nursing said the following:-She would expect nurses to give report to emergency personnel and staff be available when emergency personnel arrive;-Staff should inform the emergency personnel as to why the resident was being sent to the hospital, medications they may be on, what medications were given and any pertinent information regarding their care. During an interview on 03/10/26 the Corporate Director of Nursing said the following:-A nurse practitioner examined the resident on 03/03/26 and ordered the doppler studies due to bruising to the lower legs. When the results were in on 03/05/26, the physician ordered the resident to be sent to the hospital for evaluation;-The nurses should have documented this in the medical record;-Licensed Practical Nurse (LPN) C was the nurse on duty who sent the resident to the hospital;-LPN C should have given the emergency personnel report on the resident. 3. Review of Resident #6's face sheet showed admitted to the facility on [DATE] with diagnoses of stroke and dementia. Review of the resident's quarterly MDS dated [DATE] showed the following:-Usually able to make self-understood and usually able to understand other;-BIMS of 4 (severe cognitive impairment);-Dependent upon staff for ADL's, assist with rolling side to side, standing and transfers, dependent upon staff for walking and wheelchair mobility;-History of falls with two or more falls since admission with no injuries. Review of the resident's nurses' note dated 03/4/26 at 7:19 P.M. showed the following:-The resident rolled out of bed. His/Her bed was in the lowest position with a fall mat. He/She rolled to the right side of his/her bed, with fall mat being on the left side of the bed. He/She was found on his/her side. The resident said he/she hit his/her head. ROM and neuro assessment within normal limits for the resident. VS: BP 120/60, P 65, R 18, T 97.6. Two staff members transferred the resident back to bed. Physician and responsible party made aware. Review of the resident's medical record showed no documentation staff completed neurological checks per policy following the resident's fall on 3/4/26 at 7:19 P.M. During an interview on 03/10/26 at 3:00 P.M. the Assistant Director of Nursing said the following:-Neurological flow sheets should be completed on every unwitnessed fall;-These are documented on a paper form and uploaded into the resident's electronic medical record (EMR);-When a resident has a fall, the nurses are to complete an initial assessment in the risk management section of the EMR, this will trigger an assessment for the fall, if any neurological assessment needs to be completed and 72 hour post fall follow-up documentation;-Resident #1's fall was not entered into the EMR correctly, so no post fall assessment or documentation was triggered. No further documentation or assessment was completed after the fall. No neurological assessment was completed, and no care plan was generated to address the fall with any interventions;-Resident #6 did not have the Neurological flow sheets completed per policy. During an interview on 03/10/26 at 5:00 P.M. the Interim Director of Nursing said the following:-She would expect nurses to give report to emergency personnel and staff be available when emergency personnel arrive;-Staff should inform emergency personnel as to why the resident was being sent to the hospital, medications they may be on and what medications were given and any pertinent information regarding their care. 27912112796035

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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 plan care to address one resident's (Resident #1) of seven sampled residents, risk for falls. The facility assessed the resident for high fall risk with no care plan addressing falls. The resident fell from bed on 3/1/26 and sustained a laceration to the head. The facility failed to plan care after the resident's fall to prevent further falls. The facility census was 69. Review of the facility policy for Fall Prevention dated 11/20 showed the following:-Each resident residing at this facility will be provided services and care that ensures that the resident's environment remains free from accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents. Every resident will be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility and after every fall in the facility;-Use of the temporary, initial care plan and communication tool to identify activities or habits that place the resident at risk for falls;-The Interdisciplinary team (IDT) will develop a plan for services to improve or maintain the residents standing and sitting balance and other interventions to reduce the residents' risk for falls. The plan will include specific, individualized information about the resident's routine and personal habits that may place the resident at risk for falls;-Every team member was responsible for checking the care plan of residents who are at risk for falls when beginning each day and throughout the assigned shift. 1. Review of Resident #1's face sheet showed the resident admitted to the facility on [DATE] with diagnoses of osteomyelitis (infection in the bone) of the left ankle and foot, peripheral vascular disease (a circulation disorder) and high blood pressure. Review of the resident's Fall Risk Evaluation dated 02/16/26 showed the resident was at high risk for falls. Review of the resident's nurses notes dated 03/1/26 at 4:30 P.M. showed the following:-The resident rolled out of his/her bed, reaching for his/her phone charger, landing on the right side of his/her body. He/She was found on the floor, on the left side of the bed, between the bed and the recliner;-He/She obtained a gash to the right temple, with swelling and reported headache. 911 contacted to take the resident to the emergency room for evaluation Review of the resident's nurses' notes dated 03/1/26 at 7:51 P.M. showed the following:-Resident brought back by EMS from local hospital after fall during day shift. Resident fell out of the bed and hit head;- CT scan (a type of x-ray) of the head negative. Sutures to the forehead are intact;- Safety checks in place. Bed is low. Instructed to report dizziness or light headedness to this nurse. Plan of care ongoing. Review of the resident's comprehensive Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 03/03/26 showed the following:-Able to make self-understood and able to understand others;-Cognitively intact;-At risk for falls with no history of falls (resident sustained a fall on 3/1/26). Review of the resident's medical record from 03/01/26 through 03/10/26 showed no care plan to address the resident's fall risk or actual fall. Observation on 03/10/26 at 10:20 A.M. showed the following:-The resident lay in a low bed. The call light was located on the floor and was not within the resident's reach;-The resident had a small, closed laceration to the forehead. During an interview on 03/10/26 at 10:20 A.M. the resident said the following:-He/She had a stroke and was in the facility for therapy;-About a week ago, he/she was reaching for his/her cell phone and fell off the bed hitting his/her head on the chair;-He/She could not find the call light, so he/she tried yelling for help. He/she lay on the floor for a long time before someone came in the room. During an interview on 03/10/26 at 3:00 P.M. the Assistant Director of Nursing said the following:-When a resident has a fall, the nurses are to complete an initial assessment in the risk management section of the EMR (electronic medical record), this will trigger an assessment for the fall, if any neurological assessment needs to be completed, and 72 hour post fall follow-up documentation;-Resident #1's fall was not entered into the EMR correctly, so no post fall assessment or documentation was triggered. No further documentation or assessment was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed after the fall. No care plan was generated to address the fall with any interventions; During an interview on 03/10/26 at 4:30 P.M. the MDS coordinator said the following:-The Director of Nurses, (DON), therapy, dietary meet as a team to discuss the resident and develop a comprehensive care plan;-Resident #1 was at risk for falls and had a fall on 03/01/26 and should have a care plan;-The resident did not have a care plan for falls. During an interview on 03/10/26 at 2:40 P.M. Assistant Director of Nurses (ADON) B said the resident had no care plan to address the resident's high risk for falls or the most current fall. During an interview on 03/10/26 at 5:30 P.M. the Interim DON said the following:-She would expect any resident who was at risk for falls to have a care plan in place with interventions to help prevent falls or to limit the injury of a fall;-After a resident has a fall, the fall was investigated, and interventions should be in place. During an interview on 03/10/26 at 5:30 P.M. the Administrator said he would expect staff to follow the facility Fall Policy and develop care plans. 2791211