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	05/20/2026

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an effective pain management program for two residents (Resident #4 and #1), in a review of four sampled residents. The facility failed to consistently monitor the effectiveness of pain medication following administration to Resident #4 and to administer as needed (PRN) pain medication to ensure the resident's pain was controlled. The facility failed to ensure Resident #4 had effective pain management when he/she was out of his/her oxycodone (opioid pain reliever) from 05/16/26 until 05/20/26 and his/her pain was not controlled. The resident frequently rated his/her pain as an eight or higher (on a pain scale of 0-10 with 10 being the most pain) and staff identified the resident's pain affected his/her mood and emotions. The resident's family reported the resident did not sleep well through the night due to his/her pain. The facility failed to ensure Resident #1 had scheduled acetaminophen (pain reliever and fever reducer) as ordered, within an hour of being scheduled. The facility census was 63.Review of the facility policy, Pain Management, dated 5/2024, showed the following:-Expressions of pain may be verbal or nonverbal and are subjective to the resident including by not limited to: -Negative verbalizations and vocalizations (groaning, crying, whimpering, screaming); -Facial expressions (grimacing, frowning, fright, clenching of jaw); -Behaviors such as resisting care, distressed pacing, irritability, depressed mood or decreased participation in usual physical and/or social activities; -Difficulty sleeping.-If the resident has been identified with pain, the resident will undergo reassessment of pain at least once per shift and before and after every pain control mechanism employed by the resident care providers;-Healthcare providers from any department, that have implemented a pain control mechanism, will reassess the resident timely to determine the amount of pain control or relief achieved. Pain control mechanisms may include, but are not limited to: -Medications administered for the control or relief of pain; -Medication administered for the control or relief of anxiety; -Repositioning the resident; -Ambulation of the resident; -Visitation from family/significant other; -Monitoring appropriately for effectiveness. Review of the facility policy, Pharmacy Services, dated 5/2024, showed the following:-Provide continuity of staff to ensure medications are administered without unnecessary interruptions through; -Assuring the correct medication is administered in the correct dose, to the correct person via the correct route in the correct dosage from and at the correct time; -Defining the schedules for administering medications to maximize the effectiveness of the medication and honor resident choices and activities, as much as possible, consistent with the person centered comprehensive care plan. 1. Review of Resident #4's undated face sheet showed the following:-The resident was admitted on [DATE];-The resident was his/her own responsible party;-Diagnoses included malignant neoplasm of anus (anal cancer), fracture of the right acetabulum (right hip fracture), and wedge compression fracture of T5-T6 vertebra (the front part of the two adjoining bones in the upper back has cracked and collapsed, while the back remains intact). Review of the resident's physician orders, dated 05/07/26, showed the following:-Evaluate pain every shift;-Hydromorphone HCL (opioid pain reliever) 2 milligrams (mg), give one tablet every four hours as needed (PRN) for pain for four days;-Lorazepam (antianxiety) 1 mg, give half a tablet (0.5 mg) every 24 hours as needed for anxiety for four days, nightly;-Oxycodone HCL (opioid pain reliever) 20 mg, (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 0697 Level of Harm - Actual harm Residents Affected - Few	give one tablet every four hours PRN for pain. Review of the resident's care plan, dated 05/08/26, showed the following:-The resident had the potential for pain;-Anticipate the resident's need for pain relief and respond immediately to any complaint of pain;-Identify and record previous pain history and management of that pain and impact on function; -Identify previous response to analgesia including pain relief, side effects, and impact on function;-Monitor/document for probable cause of each pain episode. Remove/Limit causes where possible. Review of the resident's pain level log, dated 05/08/26 at 10:41 A.M., showed the resident rated his/her pain at nine out of 10 (on a scale of 0 to 10, with 10 being the worst pain). Review of the resident's physician orders, dated 05/08/26, showed the following:-Oxycodone HCL 10 mg, give two tablets orally one time only for pain for one day; -Oxycodone HCL 20 mg, give one tablet every four hours PRN for pain for four days;-Lidocaine (analgesic) external cream 5%, apply to bilateral buttocks topically every shift for radiation burns. Review of the resident's medication administration record (MAR), dated 05/08/26, showed the following:-At 11:58 A.M., staff administered oxycodone HCL 10 mg two tablets for a pain level of nine out of 10; -Staff documented the effectiveness of the medication was unknown. Review of the resident's nurse practitioner note, dated 05/08/26 at 2:08 P.M., showed the following:-The nurse practitioner assessed the resident to optimize therapy, pain control, and discharge planning;-Physical therapy will work on strengthening, endurance, training, neuromuscular training, gait training, balance training, and stairs;-Occupational therapy will work on activities of daily living (ADL) and functional mobility training;-The resident was high risk for functional impairment without therapy and adequate pain control;-Acute pain: continue to titrate pain regimen to optimize therapy performance and functional gains. Review of the resident's nursing evaluation note, dated 05/08/26 at 3:17 P.M., showed the following:-The resident had constant pain, described as throbbing and burning, that started within the last three months;-The pain affected the resident's mood and emotions;-The current interventions for pain were PRN pain medications, relaxation techniques, and distraction. Review of the resident's physician orders, dated 05/09/26, showed the oxycodone HCL 10 mg give two tablets one time only for pain for one day was discontinued. Review of the resident's MAR, dated 05/11/26 at 12:05 A.M., showed the staff administered the oxycodone HCL 20 mg to the resident for a pain level of eight out of 10. Review of the resident's MAR, dated 5/11/26, showed staff documented the oxycodone HCL 20 mg administered at 12:05 A.M. and was ineffective with the resident reporting a follow up pain level of five out of 10. (No documentation staff administered any pain medication to the resident from 12:05 A.M. through 4:35 A.M.) Review of the resident's nurse note, dated 05/11/26 at 4:28 A.M., showed the following:-The resident refused to allow the certified nurse assistants (CNAs) help with ADLs;-He/She did not sleep well that night and refused to allow staff to provide care;-He/She asked the nurse for pain medication. When the nurse gave the medication cup to the resident, he/she refused to take it and said, Why won't you talk to me? What have I done to you?-The resident gave the cup back to the nurse with the medication still in it and would not take it until the nurse answered his/her questions. Review of the resident's nurse note, dated 05/11/26 at 4:32 A.M., showed the resident was awake all night. Review of the resident's MAR, dated 05/11/26, showed the following:-At 4:36 A.M., staff administered oxycodone HCL 20 mg;-At 5:04 A.M., staff documented the oxycodone was effective with a follow up pain level at zero out of 10. Review of the resident's brief interview for mental status (cognitive assessment) note, dated 05/11/26 at 8:47 A.M., showed the resident was cognitively intact. Review of the resident's care plan, updated 05/11/26, showed the following:-The resident had a behavior problem; -Evaluate the resident for changes in pain levels and, if appropriate, request a scheduled pain medication from the physician;-Provide a calm and safe environment to allow the resident to express feelings as needed;-Anticipate the resident's need for pain relief and respond immediately to any complaint of pain;-Identify and record previous pain history and management of that pain and impact on function. -Identify previous responses to analgesia including pain relief, side effects and impact on function;-Monitor/document for probable cause of each pain episode. Remove/limit causes where possible.(The care plan did not include the (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	interventions of PRN pain medication, relaxation techniques or distractions that were identified on the nursing assessment.) Review of the resident's nurse note, dated 5/11/26 at 12:45 P.M., showed the following:-Upon the nurse entrance into the resident's room, the resident sounded like he/she had been crying;-The resident said he/she was in unbearable pain level of 11 out of 10 due to his/her spine and buttocks;-The nurse notified the physician who ordered acetaminophen 1000 mg that may be administered with the oxycodone;-The nurse explained to the resident the additional method was useful to assist with breakthrough pain. Review of the resident's physician orders, dated 05/11/26, showed a new order for acetaminophen (pain and fever reducer) 500 mg, give two tablets every eight hours PRN for pain. Review of the resident's physician orders, dated 5/12/26, showed the following:-Hydromorphone HCL 2 mg, give one tablet every four hours PRN for pain;-Lorazepam 1 mg, give half a tablet (0.5 mg) by mouth every 24 hours PRN for anxiety;-Oxycodone HCL 20 mg give one tablet by mouth every four hours PRN for pain. Review of the resident's MAR, dated 5/12/26, showed the following:-At 4:00 A.M., staff administered acetaminophen 500 mg two tablets for a pain level five out of 10;-Staff documented the effectiveness of the medication was unknown; -At 8:38 A.M., staff administered oxycodone HCL 20 mg for a pain level of 10 out of 10;-At 2:39 P.M., staff documented the 8:38 A.M. dose of oxycodone was effective with a pain level of eight out of 10. Review of the resident's medical record showed no documentation staff attempted any intervention or administered pain medication when the resident continued to have pain on 5/12/26 at 2:39 P.M. Review of the resident's MAR, dated 5/13/26, showed the following:-At 3:08 A.M., staff administered oxycodone HCL 20 mg to the resident for a pain level of six out of 10;-At 4:24 A.M., staff documented the medication was ineffective with a follow up pain level of five out of 10. (Review showed no documentation staff administered pain medication to address the resident's pain as identified at 4:24 A.M. as ineffective); -At 6:21 A.M., staff administered the hydromorphone 2 mg for a pain level at eight out of 10, (two hours after staff assessed the effectiveness of the oxycodone);-At 7:06 A.M., staff documented the hydromorphone was effective with a follow up pain level of five out of 10. Review of the resident's MAR, dated 5/15/26 at 1:10 A.M., showed staff administered oxycodone 20 mg PRN for pain level of 10 out of 10. Review of the resident's pain log, dated 5/15/26 at 2:27 A.M., showed the resident had pain at a level of five out of 10. Review of the resident's MAR, dated 5/15/26 at 8:51 A.M., showed staff administered hydromorphone 2 mg for buttock pain level of nine out of 10. Review of the resident's MAR, dated 5/15/26 at 2:59 P.M., showed staff documented the effectiveness of the hydromorphone, administered at 8:51 A.M., was unknown. Review of the resident's MAR, dated 5/15/26, showed no documentation the resident received pain medication following administration of the hydromorphone at 8:51 A.M. after staff documented the effectiveness of the medication was unknown. Review of the resident's pain level log, dated 5/15/26 at 4:35 P.M., showed the resident's pain level was 10 out of 10. Review of the resident's MAR, dated 5/15/26 on and after 4:35 P.M., showed no documentation staff administered PRN hydromorphone 2 mg or oxycodone 20 mg when the resident rated his/her pain a 10 out of 10. Review of the resident's nurse notes, dated 5/15/26 between 4:35 P.M. and 9:00 P.M., showed no documentation staff attempted any other pain alleviating interventions to address the resident's pain. Review of the resident's nurse note, dated 5/15/26 at 9:12 P.M., showed the following:-Staff gave the resident nighttime medications along with PRN pain medication, however, the resident refused to take the medication and threw the medication onto the floor;-The resident called his/her family to tell them he/she had not been given the medication, and no one had been in his/her room all night;-The resident was rude and non-compliant with care. He/She was not cooperating with the nurse or staff at the time. Review of the resident's record showed no documentation staff reassessed the resident's pain level, attempted to administer pain medication, or any other pain control interventions for the resident from 5/15/26 at 9:12 P.M. until 5/16/26 at 8:22 A.M. Review of the resident's MAR, dated 5/16/26, showed the following:-At 8:22 A.M., staff administered hydromorphone 2 mg to the resident for buttock pain level at eight out of 10;-At 9:22 A.M., staff administered oxycodone HCL 20 mg to the resident for extreme pain over his/her whole (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	body rated at 10 out of 10; -At 12:16 P.M., staff documented hydromorphone was ineffective with a follow up pain level of 10 out of 10;-At 12:27 P.M., staff administered hydromorphone 2 mg to the resident for a pain level of eight out of 10;-At 1:59 P.M., staff administered oxycodone HCL 20 mg to the resident for a pain level of at 10 out of 10. (This was the last time staff administered the oxycodone to the resident until 05/20/26.); -At 3:45 P.M., staff documented the hydromorphone and oxycodone was effective with a follow up pain level of eight out of 10;-At 4:29 P.M., staff administered hydromorphone 2 mg to the resident for pain level at eight out of 10;-At 11:42 P.M., staff documented a pain follow-up assessment as effective with follow up pain level of zero out of 10, seven hours after the hydromorphone was administered. Review of the resident's medical record showed no documentation staff notified the resident's physician on 5/16/26 when the resident rated his/her pain as an eight or 10 throughout the day and staff documented the pain medication was not effective. Review of the resident's nurse note, dated 5/17/26 at 7:27 A.M., showed the staff administered lorazepam 1 mg half a tablet to the resident because he/she was repeatedly yelling out and had increased anxiety. Staff did not document a pain assessment. Review of the resident's nurse note, dated 5/17/26 at 11:45 A.M., showed the lorazepam was effective with the resident being pleasant and calm. Review of the resident's nurse note, dated 5/17/26 at 3:58 P.M., showed the following:-The resident's family member called regarding calls he/she received from the resident; -The nurse told the resident's family member he/she administered PRN pain medication to the resident at 6:00 A.M., 7:00 A.M., 10:00 A.M., and 11:00 A.M. Review of the resident's MAR, dated 5/17/26, showed no documentation staff administered PRN pain medications at 6:00 A.M., 7:00 A.M., 10:00 A.M., and 11:00 A.M., as staff reported to the resident's family in the nurse's note at 3:58 P.M. Review of the resident's pain level log, dated 5/17/26 at 4:14 P.M., showed the resident reported pain of eight out of 10. Review of the resident's MAR, dated 5/17/26, showed no documentation staff administered PRN pain medication after 4:14 P.M. for the pain level of eight out 10. During an interview on 5/20/26 at 3:34 P.M., Licensed Practical Nurse (LPN) C said the following:-He/She worked on 5/18/26 and found the resident was out of oxycodone;-He/She reordered the oxycodone so the resident wouldn't be out when he/she returned from an appointment. Review of the resident's nurse note, dated 5/18/26 at 3:34 P.M., showed the following:-Staff at the radiology office sent the resident to the hospital from their office appointment due to pain control issues;-The hospital kept the resident for observation. Review of the resident's nurse note, dated 5/19/26 at 3:22 A.M., showed the resident returned to the facility from the hospital. Review of the resident's physician orders, dated 5/19/26, showed oxycodone HCL 20 mg, give one tablet every four hours PRN for pain. During an interview on 5/20/26 at 3:34 P.M., LPN C said the following:-On 5/19/26, the facility was still out of the resident's oxycodone because the prescription needed a signature from the physician;-He/She did not notify the physician because the resident's pain medication was effective;-He/She did not know what the resident's pain level goal was. Review of the resident's MAR, dated 5/19/26, showed the following:-At 7:51 P.M., staff administered acetaminophen 500 mg two tablets for a pain level at eight out of 10;-At 9:25 P.M., staff administered hydromorphone 2 mg for a pain level at eight out of 10;-At 11:58 P.M., staff documented the acetaminophen was ineffective with a follow up pain scale level of six out of 10;-At 11:59 P.M., staff documented the hydromorphone was ineffective with a follow up pain scale level of six out of 10. Review of the resident's nurse notes, dated 5/19/26, showed no documentation staff notified the resident's physician when the resident's pain medication was not effective, the resident was out of oxycodone, nor any attempts for non-pharmacological interventions to address the resident's pain. Review of the resident's MAR, dated 5/20/26, showed the following:-At 1:25 A.M., staff administered hydromorphone 2 mg over an hour after the resident reported pain of six out of 10;-At 4:13 A.M., staff administered oxycodone HCL 20 mg for a pain level of seven out of 10;-At 5:07 A.M., staff documented the hydromorphone effectiveness was unknown with a follow up pain level of five out of 10;-At 5:08 A.M., staff documented the oxycodone effectiveness was unknown with a follow up pain level of five out of 10;-At 5:46 A.M., staff (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	administered hydromorphone 2 mg for a pain level of five out of 10;-At 9:54 A.M., staff documented the hydromorphone effectiveness was unknown. During an interview on 5/20/26 at 3:32 P.M., LPN B said the following:-The resident was out of oxycodone on the night shift of 5/19/26 until it was delivered the early morning of 5/20/26;-Once the oxycodone was delivered, he/she administered 20 mg to the resident;-He/She did not notify the physician the facility did not have the oxycodone available;-He/She did not have access to get the oxycodone out of the emergency medication machine;-He/She explained to the family and the resident the medication was supposed to be delivered, and he/she would give the resident the pain medication that was available in the facility. During an interview on 5/20/26 at 11:40 A.M., the resident said the following:-The facility was out of his/her PRN oxycodone 20 mg; -The hydromorphone alone was not effective to control his/her pain;-The facility finally received the oxycodone and administered it in the early morning on 5/20; -He/She had to wait sometimes for two hours before the staff administered the pain medications after he/she requested them;-His/Her goal for a pain level would be no pain, but a tolerable pain level would be four or below;-The resident had a terrible time the night before and couldn't sleep due to the pain. During an interview on 5/20/26 at 11:42 A.M., the resident's family member said the following:-The resident had trouble sleeping at night related to pain;-The family member said the resident was trying to catch up on the PRN pain medication so he/she could get some sleep;-The family did not feel the staff kept the resident's pain tolerable. The resident called the family to complain about being in pain and no staff checked on him/her nor gave any pain medications;-When the resident was in the hospital, the pain medication was on a schedule and that worked well, but at the facility, the physician only ordered pain medication on a PRN basis;-He/She, another family member, and a family friend had to ask staff for pain medication for the resident, otherwise, it was a long wait or the staff forgot;-Since the resident's last visit to the hospital, the resident's family took turns to ensure there was someone with the resident around the clock to ensure his/her pain was controlled. During an interview on 5/20/26 at 3:32 P.M., LPN B said the following:-The resident was able to tell staff he/she was in pain and how bad the pain felt.-He/She did not know what the resident's pain level goal was. He/She just administered pain medication when the resident or family requested it;-The staff were supposed to follow up with the resident on the effectiveness of the pain medication and document it;-When he/she documented the effectiveness was unknown, it was because the resident had an improvement on pain severity, but it was still present, therefore, the medication was neither effective nor ineffective but unknown. 2. Review of Resident #1's face sheet, undated, showed the following:-The resident was admitted on [DATE];-He/She was his/her own responsible party;-Diagnosis of displaced trimalleolar fracture of left lower leg (severe and unstable three-part break of the ankle joint where the bones have shifted out of their normal position). Review of the resident's nursing evaluation, dated 5/7/26 at 5:16 P.M., showed the following:-He/She described pain as it hurts a little bit, did not radiate, occasional/intermittent that was aching with onset within last seven days, and it affected sleeping;-Current pain medication regimen was narcotics on PRN basis. Review of the resident's physician orders, dated 5/7/26, showed the following:-Acetaminophen (pain reliever and fever reducer) 500 mg give two tablets by mouth every eight hours scheduled for pain;-Baclofen (skeletal muscle relaxant) 10 mg give one tablet by mouth, every eight hours PRN for spasms;-Hydrocodone/Acetaminophen (narcotic analgesic combination) 7.5/325 mg, give one tablet by mouth every twelve hours PRN for severe pain;-Ibuprofen (non-steroidal anti-inflammatory) 600 mg give one tablet by mouth every six hours PRN for pain. Review of the resident's MAR, dated 5/8/26, showed staff administered acetaminophen 500 mg, two tablets at 9:01 P.M. for pain level of eight out of 10. Staff did not document the effectiveness of the medication. Review of the resident's MAR, dated 5/9/26, showed staff administered acetaminophen 500 mg two tablets at 2:00 P.M. without assessment of the resident's pain level. Staff did not document the effectiveness of the medication. Review of the resident's MAR, dated 5/10/26, showed staff administered the acetaminophen 500 mg two tablets at 2:00 P.M., without assessment of the (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	resident's pain level. Staff did not document the effectiveness of the medication. Review of the resident's physician orders, dated 5/10/26, showed evaluation pain every shift. Review of the resident's brief interview for mental status, dated 5/11/26 at 8:45 A.M., showed the resident was cognitively intact. Review of the resident's pain level log, dated 5/12/26 at 3:18 P.M., showed staff administered the acetaminophen scheduled at 2:00 P.M. over an hour late, for pain level at eight out of 10. Review of the resident's pain level log, dated 5/15/26 at 3:15 P.M., showed staff administered the acetaminophen scheduled for 2:00 P.M., over an hour late, for a pain level at five out of 10. Review of the resident's MAR, dated 5/19/26, showed the staff administered the acetaminophen 500 mg two tablets at 2:00 P.M., without assessment of the pain level. Staff did not document the effectiveness of the medication. Review of the resident's pain level log, dated 5/19/26 at 11:06 P.M., showed staff administered the acetaminophen scheduled for 10:00 P.M. over an hour late, for a pain level at five out of 10. During an interview on 5/20/26 at 1:05 P.M., the resident said the following:-His/Her goal was to have a pain level at four or below;-On the night shift, he/she experienced the longest wait time for pain medication;-He/She observed a staff member administer everyone's scheduled medications prior to administering his/her PRN pain medications when requested;-It felt like he/she had to wait two hours for the PRN pain medication;-That was frustrating because when he/she was in pain and had to wait for the PRN pain medication, then he/she had to wait for the pain medication to become effective;-It was also frustrating when the staff were late with his/her scheduled pain medication, because he/she experienced breakthrough pain. 3. During an interview on 5/20/26 at 3:37 P.M., the Director of Nursing (DON) said the following:-Staff were to follow the physician orders of checking resident's pain level every shift, prior to administration of the medication, and after administration of the medication;-If a resident's pain was not tolerable with current interventions, then the nurse should contact the physician;-If a resident had a current prescription for a narcotic but none were available, then the nurse could obtain the medication from the emergency kit;-If a resident did not have a current prescription for a narcotic, then he/she had to contact the physician to send an electronically signed order to the pharmacy, then the pharmacy made the medication available to obtain from the emergency kit;-The nurse had to be entered into the system and fingerprinted to get medication from the emergency kit;-Newer nurses may not be in the system or fingerprinted yet;-He/She was unaware LPN B did not have access to the emergency kit;-Staff was to administer scheduled medications within an hour of the scheduled time and PRN medications as soon as possible after being requested. During an interview on 5/20/26 at 4:06 P.M., the Administer said the following:-Staff were to follow the physician orders on administering pain medications and follow up to ensure the medication was effective;-The staff was to follow the policy on medication administration times;-If the resident's pain level was not tolerable, then the nurse was to contact the physician. Complaint # 3017040