

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/24/2025
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NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR OF ST PETERS	STREET ADDRESS, CITY, STATE, ZIP CODE 268 JUNGERMANN ROAD SAINT PETERS, MO 63376
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4504	19 CSR 30-86.045(3)(A)(4) More Than Minimal Assist - Staff, Awake General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 4. Have sufficient staff present and awake twenty-four (24) hours a day to assist in the evacuation of all residents; I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to have sufficient staff present twenty-four (24) hours per day to assist in the evacuation of all residents based on the necessity of one resident (Resident #1) of 11 sampled residents, needing more than minimal assistance due to physical impairment that prevented the individual from safely evacuating the facility independently. The facility census was 11. Review of the facility's undated Evacuation Plan showed the following: - The Evacuation Plan was one element of the facility Disaster Plan; - The Disaster Plan was to be available to all employees working at the facility; - Copies of the Disaster Plan were to be maintained in the Emergency Preparedness Book in red binders in the staff break room, medication rooms, administrator's office, clinic nurse manager's office, and the community director's office;	A4504		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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(X6) DATE

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A4504	19 CSR 30-86.045(3)(A)(4) More Than Minimal Assist - Staff, Awake General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 4. Have sufficient staff present and awake twenty-four (24) hours a day to assist in the evacuation of all residents; I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to have sufficient staff present twenty-four (24) hours per day to assist in the evacuation of all residents based on the necessity of one resident (Resident #1) of 11 sampled residents, needing more than minimal assistance due to physical impairment that prevented the individual from safely evacuating the facility independently. The facility census was 11. Review of the facility's undated Evacuation Plan showed the following: - The Evacuation Plan was one element of the facility Disaster Plan; - The Disaster Plan was to be available to all employees working at the facility; - Copies of the Disaster Plan were to be maintained in the Emergency Preparedness Book in red binders in the staff break room, medication rooms, administrator's office, clinic nurse manager's office, and the community director's office;	A4504		

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A4504	Continued From page 1 - The Evacuation Plan called for residents, staff, and visitors to be evacuation from the facility due to fire and residents were to be moved into an adjacent, unaffected smoke compartment/safe area of refuge; - If the building were determined to be uninhabitable, all residents and staff were to be evacuated from the building to a point of refuge; - In case of a fire, the plan called for staff to remove residents from immediate danger into the next unaffected smoke/fire compartment, direct residents to the appropriate area for safety, and let residents know about the concern and help them move to an unaffected area; - The Fire Safety Plan identified that all employees were to be trained on fire routes, location of extinguishers, fire alarms, fire panel, fire doors, smoke compartments, generator locations, locations of furnaces, locations of circuit breakers, and locations of gas and water main entry points; - The Fire Safety Plan called for training to include how to evacuate resident rooms and mark a room cleared, location of areas of assembly and areas of refuge, and the general physical layout of the building; - Review of the Evacuation and Fire Safety Plans showed no references to residents needing more than minimal assistance with evacuation and no references to readily-available documentation of Individual Evacuation Plans for residents who required more than 3 verbal prompts and/or more than 2 or more forms of physical assistance (including transfer) in order to evacuate safely. Review of the facility's evacuation map showed a black and white floor plan which showed resident rooms and common areas with external exits and routes to exits identified in red ink. The facility	A4504		

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A4504	Continued From page 2 evacuation map showed no specific notation showing areas of refuge within the facility. 1. Observation on 6/23/25 at 10:07 P.M., showed the following: The only staff in the building were two caregivers (Caregiver A and Caregiver B) assigned to provide care for 11 residents; -Caregiver A worked in the assisted living wings of the facility providing oversight for nine residents, eight residents were capable of evacuating with minimal assistance and one resident was bed-bound and required more than minimal assistance to evacuate; -Caregiver B worked in the memory care unit which was separated from the assisted living wings by a locked door providing oversight for two residents who were able to evacuate with minimal assistance. 2. Review of Resident #1's file showed the following: -Admission date 2/15/25; -Diagnosis was primary hypertension (high blood pressure); -Community based assessment (CBA) 2/6/25 showed the resident used a wheelchair, needed some assistance with transfers, and was not able to safely evacuate the facility with minimal assistance; -The CBA did not specify the number of staff necessary to transfer the resident; -Individualized service plan (ISP) 6/24/25 showed the resident was bed-bound, could no longer bear weight for transfers, and needed to be taken to a safe location by staff during an emergency; -The ISP did not specify the number of staff necessary to transfer the resident; -The individualized service plan did not include	A4504		

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A4504	Continued From page 3 an individualized evacuation plan for this resident. During interview on 6/24/25 at 12:23 P.M., Resident #1 said the following: -He/She was on hospice and received care and assistance from hospice and facility staff; -He/She was not able to get out of bed independently; -It usually took one or two staff members to turn him/her in the bed; -He/She had not been out of bed into the wheelchair since initially moving into the facility; -It took two staff members to move the resident from the bed to the wheelchair and back. During interview on 6/23/25 at 10:07 P.M., Caregiver A said the following: -There were two staff working in the building for second shift until 11:00 P.M.; -There were two staff scheduled to work third shift starting at 11:00 P.M. to 7:00 A.M.; -Caregiver B worked in the memory care unit which had a locked door separating it from the assisted living wings; -A Level One Medication Aide (LIMA)(LIMA C), had worked over from day shift in order to administer bedtime medications and had clocked out around 8:00 P.M.; -One resident, Resident #1, was bed-fast and required two persons to transfer the resident from the bed to wheelchair; -Resident #1 was not physically able to assist with staff efforts during transfer; -He/She was not sure how he/she would evacuate the resident who required assistance with transfer; -He/She had not received training on the emergency evacuation needs of Resident #1.	A4504		

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A4504	Continued From page 4 During interview on 7/10/25 at 7:08 A.M., Caregiver D said the following: -Prior to 6/24/25, the Executive Director insisted on only scheduling two staff per shift; -He/She had worked many shifts as one of only two staff in the facility for 11 residents; -He/She did not think two staff would be sufficient to safely evacuate the residents from assisted living who needed minimal assistance, the two residents from memory care who required minimal assistance and constant supervision, and the assisted living resident who required two-person transfer from bed to chair to an area of refuge or to safely exit the building in a timely manner; -He/She had not received training on the facility plans to safely evacuate the residents; -He/She had not seen a written facility evacuation plan or individual evacuation plan for any residents; -He/She had not participated in a fire drill that involved the evacuation of any residents. During interview on 7/10/25 at 8:45 A.M., Caregiver E said the following: -On the 3rd shift from 6/23/25 at 11:00 P.M. to 6/24/25 at 7:00 A.M., there were only two staff members on site for 11 residents; -One staff member was in the assisted living wing and one was in the memory care unit behind a locked door; -Resident #1 required a two-person assist to transfer from the bed to a wheelchair for evacuation; -The two residents in the memory care unit could not be left unattended during an evacuation or when an assisted living resident required assistance;	A4504		

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A4504	Continued From page 5 -He/She had not participated in a fire drill that involved evacuation of the residents; -He/She had not received training on evacuation needs of the residents; -He/She would not know where to take the residents in case of an emergency because staff had not been trained; -He/She did not feel that two staff were sufficient for the safety of the residents because it was not enough staff to evacuate the assisted living residents who needed minimal assistance, the memory care residents who could not be left unattended and needed minimal assistance, and Resident #1 who needed a two-person transfer for evacuation in a timely manner; -He/She was not aware of a written emergency evacuation plan for the facility or an individual evacuation plan for Resident #1. During interview on 6/23/25 at 10:32 P.M. and on 6/24/25 at 12:30 P.M., the Executive Director said the following: -He was aware that Resident #1 was bed bound and required more than minimal assistance for evacuation; -He was not aware that the facility was required to have additional staff on-duty to provide for emergency evacuation for Resident #1; -He thought the facility was sufficiently staffed with one staff in the assisted living wings and one staff in the memory care unit; -It was his intention to properly staff the facility according to resident needs and regulation.	A4504		
A4512	19 CSR 30-86.045(3)(A)(10) Comply with All Req. of Section (3) of rule General Requirements. (A) If the facility admits or retains any individual	A4512		

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A4512	Continued From page 6 needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 10. Comply with all requirements of this rule. I/II This regulation is not met as evidenced by: Class II Based on observation, interview, and record review, the facility failed to ensure residents who needed more than minimal assistance due to physical or cognitive impairments had an individualized evacuation plan (IEP) in the resident's individual service plan (ISP), that the IEP listed the responsibilities of specific staff positions in an emergency specific to the individual, that the IEP included specific interventions needed to ensure the safety of the resident, that the IEP included the resident's location within the facility including proximity to exits and areas of refuge and risk of resistance, mobility, and need for additional staff support, that employees with specific responsibilities received training regarding their duties and responsibilities under the resident's evacuation plan, and that the written IEP be readily available to all staff for one resident (Resident #1) who required assistance of two staff to transfer of 11 sampled residents. The facility census was 11. Review on 6/24/25 of Resident #1's file showed the following: -Admission date 2/15/25; -Diagnosis of essential hypertension (high blood pressure); -Community based assessment dated 2/6/25 showed the resident used a wheelchair, needed	A4512		

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A4512	Continued From page 7 some assistance with transfers, and was not able to safety evacuate the facility with minimal assistance; -Individualized service plan as of 6/24/25 showed the resident was bed-bound, could no longer bear weight for transfers, and needed to be taken to a safe location by staff during an emergency; -The individualized service plan did not include an individualized evacuation plan for the resident. During interview on 6/24/25 at 12:23 P.M., Resident #1 said the following: -He/She was on hospice and received care and assistance from hospice and facility staff; -He/She was not able to get out of bed independently; -It usually took one or two staff members to turn him/her in the bed; -He/She had not been out of bed into the wheelchair since initially moving into the facility; -It took two staff members to move the resident from the bed to the wheelchair and back. During interview on 6/23/25 at 10:07 P.M., Caregiver A said the following: -One resident, Resident #1, was bed bound and required more than one person to transfer the resident from the bed to a wheelchair; -The resident was not physically able to assist with staff efforts during transfer; -He/She was not aware of a written plan for Resident #1's emergency evacuation; -He/She had not received training on the emergency evacuation needs of Resident #1. During interview on 6/23/25 at 10:32 P.M. and on 6/24/25 at 12:30 P.M., the Executive Director said the following: -He was aware that Resident #1 was bed bound	A4512		

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A4512	Continued From page 8 and required more than minimal assistance for evacuation; -He was not aware the facility was required to assess and plan an IEP for all residents who required more than minimal assistance for evacuation.	A4512		
A4518	19 CSR 30-86.045(4)(F) Staffing-Licensed Nurse Responsibilities The licensed nurse shall be available to assess residents for pain and significant and acute changes in condition. The nurse ' s duties shall include, but shall not be limited to, review of residents ' records, medications, and special diets or other orders, review of each resident ' s adjustment to the facility, and observation of each individual resident ' s general physical, psychosocial, and mental status. The nurse shall inform the administrator of any problems noted and these shall be brought to the attention of the resident ' s physician and legally authorized representative or designee. II/III This regulation is not met as evidenced by: Class II* Based on observation and interview, the facility failed to ensure a licensed nurse was available to assess residents for pain and significant and acute changes in condition including the review of resident records and observation of resident conditions with the potential to impact all residents at the facility. The facility census was 11. During observation on 6/12/25, 6/23/25, and 6/24/25, there was no licensed nurse employed by the facility to assess and observe resident	A4518		

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A4518	Continued From page 9 conditions. During interview on 6/12/25 at 8:27 A.M. and 6/23/25 at 10:32 A.M. and 12:30 P.M., showed the the Executive Director said the following: -The former administrator had been working as the administrator and Director of Nursing; -He was aware the facility was required to employ a licensed nurse. -Previous attempts to hire a licensed nurse been unsuccessful; -It was his intention to move the licensed administrator who was also a licensed nurse from a sister-facility on 6/24/25; -He had been relying on the residential care coordinator (RCC) who was not a nurse to alert him to any changes in resident conditions; -It was his intention to hire a licensed administrator who was also a licensed nurse to meet this requirement. During interview on 6/24/25 at 11:30 A.M., the licensed nurse for the sister-facility said the following: -She was onsite at the facility to provide assistance in providing resident record information for surveyors; -She was not employed by the facility as a nurse. *The higher classification merited due to the extent of the violation.	A4518		
A4703	19 CSR 30-86.047(5) Administrator - Licensed The operator shall designate an individual for administrator who is currently licensed as an administrator by the Missouri Board of Nursing Home Administrators, in accordance with	A4703		

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A4703	Continued From page 10 Chapter 344, RSMo. II This regulation is not met as evidenced by: Class II Based on observation, interview and record review, the facility failed to ensure a licensed administrator was employed at the facility as required. The facility census was 11. Review of the Temporary Emergency License (TEL) issued by the Missouri Board of Nursing Home Administrators (BNHA) posted at the facility on 6/12/25 showed that the TEL for the former administrator was issued on 3/20/25 with an expiration date of 7/18/25. During observation on 6/12/25, 6/23/25, and 6/24/25, the former administrator was not at the facility serving as the administrator. During observation on 6/12/25 and 6/25/25, there was no licensed administrator assigned to the facility present in the building and the residential care coordinator (RCC) was providing oversight for resident care and staffing concerns. During interview on 6/12/25 at 8:27 A.M., the executive director said the following: -He was not a licensed administrator in the state of Missouri; -The former administrator was no longer employed by the facility and left employment with the facility unexpectedly; -He was aware the facility was required to have a licensed administrator.- During interview on 6/23/25 at 10:32 P.M., the executive director said the following:	A4703		

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A4703	Continued From page 11 -Previous attempts to hire a new administrator had been unsuccessful; -It was his intention to move the fully-licensed administrator from a sister-facility on 6/24/25 and request a TEL for a new administrator at the sister-facility. During interview on 6/24/25 at 11:30 A.M., the licensed administrator for the sister-facility said the following: -She was onsite at the facility to provide assistance in providing resident record information for inspectors; -She was not serving as the administrator for the facility and was registered as the licensed administrator at the sister-facility on that date. During interview on 6/23/25 at 12:30 P.M., the executive director said the following: -He was aware the facility was required to have a licensed administrator providing oversight for resident and staff needs; -He had been relying on the RCC to provide those services while he recruited a new administrator.	A4703		
A4781	19 CSR 30-86.047(40) Self-Control of Medication Requirements Self-control of prescription medication by a resident may be allowed only if approved in writing by the resident ' s physician and included in the resident ' s individualized service plan. A resident may be permitted to control the storage and use of nonprescription medication unless there is a physician ' s written order or facility policy to the contrary. Written approval for self-control of prescription medication shall be rewritten as needed but at least annually and	A4781		

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A4781	Continued From page 12 after any period of hospitalization. II/III This regulation is not met as evidenced by: Class III Based on observation, interview and record review, the facility failed to obtain a physician's order for three of 11 sampled residents (Resident #1, #2, and #3) to self-administer medications. The facility census was 11. 1. Observation on 6/24/25 at 12:23 P.M. of Resident #1's private apartment showed a bottle of hydrogen peroxide (an over-the-counter medication used for wound care and to treat fungal infections of the skin) on the bedside table within reach of the bed-bound resident. Review of the resident's facility record showed the following: -Admission date of 2/15/25; -Diagnosis was essential hypertension (high blood pressure); -No physician's order for hydrogen peroxide and no physician's order authorizing the self-administration of any prescription or over-the-counter medications. 2. Observation on 6/24/25 at 9:53 A.M. of Resident #2's private apartment showed a bottle of over-the-counter Tylenol (brand-name version of acetaminophen, an over-the-counter medication to treat pain) and a bottle of saline nasal spray (over-the-counter spray to treat dry or irritated nasal passages) on an end-table next to the resident's chair. Record review of the resident's facility record showed the following:	A4781		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/24/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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A4781	Continued From page 13 -Admission date of 5/30/25; -No diagnoses listed on the face sheet, physician order sheets (POS), or medication administration record (MAR); -No physician order for acetaminophen or saline nasal spray and no physician's order authorizing the self-administration of any prescription or over-the-counter medications. During interview on 6/24/25 at 9:53 A.M., the resident said he/she did not take the acetaminophen or use saline nasal spray and did not know why they were on the table next to his/her chair. 3. Observation on 6/24/25 at 10:22 A.M. of Resident #3's private apartment showed a tube of diclofenac 1% cream (a topical over-the-counter medication to treat pain and inflammation). Review of Resident #3's facility record showed the following: -Admission date of 3/31/25; -Diagnoses of essential hypertension and Alzheimer's disease (a disorder of thoughts and memory); -No physician's order for diclofenac 1% cream and no physician's order authorizing the self-administration of any prescription or over-the-counter medications. 4. During interview on 6/24/25 at 12:30 P.M., the Executive Director said the following: -He was aware a physician's order was required for residents to have medications in their rooms for self-administration; -He relied on the director of nursing to audit physician orders to include orders for	A4781		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/24/2025
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A4781	Continued From page 14 self-administration of medications; -The facility nurse had resigned unexpectedly, and the facility did not have a nurse to audit physician orders for resident self-administration of medications. -	A4781		
A4837	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a reasonable likelihood of serious harm to himself or herself or others and accidents that potentially could result in injury or did result in injuries involving the resident; III This regulation is not met as evidenced by: Class III Based on interview and record review, the facility failed to ensure a monthly weight and resident condition review was completed for nine residents (Residents #1, #3, #4, #5, #6, #7, #8,	A4837		

Missouri Department of Health and Senior Services

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A4837	Continued From page 15 #10, and #11) of 11 sampled residents. The facility census was 11. 1. Record review of Resident #1's file showed the following: -Admission date of 2/15/25; -Diagnosis of essential hypertension (high blood pressure); -Monthly Wellness Visit note from the former Director of Nursing dated 5/6/25 that did not include specific information related to the resident's weight and condition; -No monthly condition reviews for February, March, or April 2025. 2. Record review of Resident #3's file showed the following: -Admission date of 3/31/25; -Diagnoses of essential hypertension and Alzheimer's disease (a disorder of thoughts and memory); -No monthly condition reviews for April or May 2025. 3. Record review of Resident #4's file showed the following: -Admission date of 12/19/24; -Diagnosis of hearing loss; -Monthly Wellness Visit notes from the former Director of Nursing dated 2/20/25 and 5/23/25 that did not include monthly weights; -No monthly condition reviews for December 2024 and January, March, and April 2025. 4. Record review of Resident #5's file showed the following: -Admission date of 12/19/24; -Diagnosis of essential hypertension; -Monthly Wellness Visit notes from former	A4837		

Missouri Department of Health and Senior Services

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A4837	Continued From page 16 Director of Nursing dated 1/20/25, 2/20/25, and 5/23/25 that did not include monthly weights; -No monthly condition reviews for December 2024 and March and April 2025. 5. Record review of Resident #6's file showed the following: -Admission date of 5/1/25; -Diagnoses of essential hypertension and anxiety disorder (disorder characterized by persistent fear); -No monthly condition review for May 2025. 6. Record review of Resident #7's file showed the following: -Admission date of 1/30/25; -Diagnosis of essential hypertension; -Monthly Wellness Visit note from former Director of Nursing dated 5/23/25 that did not include current weight; -No monthly condition reviews for February, March, or April 2025. 7. Record review of Resident #8's file showed the following: -Admission date of 2/6/25; -Diagnosis of unspecified dementia (disorder which impacts thoughts and memories); -No monthly condition reviews for February, March, April, or May 2025. 8. Record review of Resident #10's file showed the following: -Admission date of 12/20/24; -Diagnoses of unspecified dementia and major depressive disorder (disorder characterized by persistent sadness); -Monthly Wellness Visit note by former Director of Nursing dated 1/23/25 which did not include	A4837		

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR OF ST PETERS		STREET ADDRESS, CITY, STATE, ZIP CODE 268 JUNGERMANN ROAD SAINT PETERS, MO 63376			
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A4837	Continued From page 17 current weight; -No monthly condition reviews for December 2024 and February, March, April, and May 2025. 9. Record review of Resident #11's file showed the following: -Admission date of 2/28/25; -Diagnoses of essential hypertension and chronic obstructive pulmonary disease (breathing disorder); -No monthly condition reviews for March, April, or May 2025. 10. During interview on 6/24/25 at 12:30 P.M., the Executive Director said the following: -He relied on the Director of Nursing to complete monthly condition reviews for residents; -The facility nurse had resigned unexpectedly, and the facility did not have a nurse to complete and audit the monthly condition reviews for residents; -It was his expectation that the Director of Nursing, would complete and audit the required monthly condition reviews for residents.	A4837			

PLAN OF CORRECTION

Provider/Supplier Name:	Hampton Manor of St Peters	
Street Address, City, Zip:	268 Jungerman Rd, St Peters, MO 63376	
Date of Survey:	6/24/2025	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4504	Additional staff has been added to schedule to ensure communities ability to evacuate residents including Resident #1 Administrator/designees to in-service staff on fire safety plan/evacuation Administrator/designee to in-service nursing management on Staffing requirements Administrator/designee to audit nursing staffing level weekly for 4 weeks Administrator/designee to report audit and staffing level to quarterly QAPI to ensure continued compliance	8/22/2025
A4512	Resident #1 ISP and IEP has been updated with required information Administrator/designee to in-service nursing management on ISP and IEP requirements All residents ISP/IEP were audited to ensure correct ISP to be audited monthly for 3 months and then quarterly there after Administrator/designee to report audit results to quarterly QAPI to ensure continued compliance	8/22/2025
A4518	Community transferred nurse to community from sister community on 7/3/2025 – Nurse resigned 8/7/2025 – new nurse hired to start 8/18/2025 Nurse from Hampton Manor of Wentzville to assist till new nurse starts in accordance with cross coverage agreement Administrator to in-service RDO on nursing requirement for community	8/22/2025

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR OF ST PETERS		STREET ADDRESS, CITY, STATE, ZIP CODE 268 JUNGERMANN ROAD SAINT PETERS, MO 63376			
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{A4512}	19 CSR 30-86.045(3)(A)(10) Comply with All Req.of Section (3) of rule General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 10. Comply with all requirements of this rule. I/II This regulation is not met as evidenced by: This deficiency is uncorrected. For prior examples, please the Statement of Deficiencies dated 6/24/25. Class II Based on observation, interview, and record review, the facility failed to ensure two residents (Resident #1 and #4), of twelve sampled residents, who needed more than minimal assistance due to physical or cognitive impairments, had an individualized evacuation plan (IEP, a plan specific to the resident to safely evacuate the resident in case of an emergency) that included all required elements and was readily available to staff. The facility also failed to ensure staff were instructed on specific responsibilities and their duties and responsibilities under the resident's evacuation plan as required. The facility census was 12. Upon request, facility staff reported they had no access to written policies including policies for IEPs. 1. Review of Resident #1's facility electronic medical record dashboard showed the following: -Admission date of 8/1/25;	{A4512}			

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

4EZB12

If continuation sheet 1 of 29

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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{A4512}	19 CSR 30-86.045(3)(A)(10) Comply with All Req.of Section (3) of rule General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 10. Comply with all requirements of this rule. I/II This regulation is not met as evidenced by: This deficiency is uncorrected. For prior examples, please the Statement of Deficiencies dated 6/24/25. Class II Based on observation, interview, and record review, the facility failed to ensure two residents (Resident #1 and #4), of twelve sampled residents, who needed more than minimal assistance due to physical or cognitive impairments, had an individualized evacuation plan (IEP, a plan specific to the resident to safely evacuate the resident in case of an emergency) that included all required elements and was readily available to staff. The facility also failed to ensure staff were instructed on specific responsibilities and their duties and responsibilities under the resident's evacuation plan as required. The facility census was 12. Upon request, facility staff reported they had no access to written policies including policies for IEPs. 1. Review of Resident #1's facility electronic medical record dashboard showed the following: -Admission date of 8/1/25;	{A4512}		

Missouri Department of Health and Senior Services

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TITLE

(X6) DATE

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{A4512}	Continued From page 1 -Diagnoses included acute respiratory failure (breathing disorder), chronic obstructive pulmonary disease (breathing disorder), difficulty in walking, epilepsy (seizure disorder), lung and brain cancer and cognitive communication deficit (problem with speech and language comprehension). Review of the resident's Community Based Assessment (CBA, document which identifies the resident's abilities, needs, and limitations) dated 8/1/25, showed the resident required assistance with walking/mobility and used a wheelchair as an assistive device for mobility. Review of the resident's ISP dated 8/1/25 showed the resident needed hands on assistance to get out of bed and into a wheelchair, caregiver assistance to propel the wheelchair, and verbal and physical direction in response to an emergency; -The IEP did not identify the resident's specific requirements for evacuation assistance including the resident's need for transfer assistance and no identification of the specific actions to be taken by staff responsible for the resident's evacuation in the event of an emergency including which staff position was responsible for transferring the resident to the wheelchair and propelling the resident's wheelchair into a safe area. Observation of the resident on 8/28/25 showed the following: -The resident was in bed with a bolster mattress (mattress with elevated sides); -The resident's bed had fall protection pads on the floor beside each side of the bed; -The resident's wheelchair was in an adjacent room and inaccessible to the resident; -Hospice staff present and providing personal	{A4512}			

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{A4512}	Continued From page 2 care for the resident; -The resident did not respond to verbal communication; -No posted evacuation plan located in the room. Observation of the nurses's station on 8/28/25 at 3:30 P.M.. showed no posted evacuation plan for the resident which included the resident's specific evacuation needs and the staff responsible for assisting the resident during an evacuation. During interview on 8/28/25 at 3:00 P.M., Caregiver A said the resident required assistance to transfer from bed to a wheelchair for evacuation. He/She did not have access to a written IEP for the resident and had received no evacuation training specific to the resident's evacuation needs. 2. Review of Resident #4's electronic medical record dashboard showed the following: - Admission on 8/7/25; - Diagnoses included congestive heart failure (heart disorder), glaucoma (vision disorder), osteoarthritis (bone and joint disease), mild dementia (disorder of that affects thought processes and memory), neuropathy (nerve disorder causing pain and numbness in the arms or legs), and lumber stenosis (spine disorder that affects nerves and movement). Review of the resident's admission nursing assessment dated 8/7/25 showed the resident could not ambulate independently and needed maximum assistance to transfer. Review showed no CBA in the resident's electronic or physical facility record. Review showed no ISP in the resident's electronic	{A4512}			

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{A4512}	Continued From page 3 or physical facility record. Review showed no IEP in the resident's electronic or physical facility record. Review of the resident's admission documentation stated the resident could not ambulate independently and needed maximum assistance to transfer. Observation of the nurses's station and the resident's room on 8/28/25 at 3:30 P.M., showed no posted evacuation plan for the resident. During interview on 8/28/25 at 3:37 P.M., the resident said the following: -He/She needed transfer assistance from staff to get from the bed to the wheelchair or from the wheelchair to the bed; -Staff used a gait belt for transfers; -Staff had said he/she required more assistance than other residents. During interview on 8/28/25 at 3:00 P.M., Caregiver A said the resident needed assistance to transfer from the bed to a wheelchair for evacuation. He/She had no access to a written IEP for the resident either online or in the resident's physical record. He/She had not received training specific to the resident's evacuation needs. 3. During interview on 8/28/25 between 9:45 A.M. and 5:10 P.M., the Executive Director said the following: - The facility did not employ a staff member who was certified to complete resident CBAs, ISPs, and IEPs. The facility relied on the availability of trained staff from a sister facility to complete the required documentation;	{A4512}		

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{A4512}	Continued From page 4 - The Executive Director was not aware Resident #4 did not have IEP in his/her facility record and was unaware that care staff had not been trained in the evacuation needs of individual residents.	{A4512}		
{A4518}	19 CSR 30-86.045(4)(F) Staffing-Licensed Nurse Responsibilities The licensed nurse shall be available to assess residents for pain and significant and acute changes in condition. The nurse ' s duties shall include, but shall not be limited to, review of residents ' records, medications, and special diets or other orders, review of each resident ' s adjustment to the facility, and observation of each individual resident ' s general physical, psychosocial, and mental status. The nurse shall inform the administrator of any problems noted and these shall be brought to the attention of the resident ' s physician and legally authorized representative or designee. II/III This regulation is not met as evidenced by: This deficiency is uncorrected. For prior examples, please see the Statement of Deficiencies dated 6/24/25. Class II* Based on observation and interview, the facility failed to ensure a licensed nurse was available to assess residents for pain and acute changes in condition. The facility census was 12. Observations on 8/28/25 between 9:45 A.M. and 5:09 P.M., showed there was no licensed nurse at the facility. During interview on 8/28/25 at 11:18 A.M.,	{A4518}		

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{A4518}	Continued From page 5 Resident #5 said the following: -He/she had only seen a nurse a few times since admission several months prior; -He/she had a concerning rash and pain and had notified care staff of his/her concerns several days before; -He/She had been told by care staff several days before, that a nurse would assess the rash but he/she had not seen a nurse.. During interview on 8/28/25 at 11:06 A.M., Resident #5's family member said the following: -The resident had been experiencing pain and a rash for more than one month; -The resident and family reported the rash and pain to care staff several days before and were told by a care staff at that time a nurse would visit to assess the resident; -No licensed or registered nurse had seen the resident to assess the rash and pain; -There was no nurse to assess and treat residents; -The facility relied on nursing staff from a sister facility as available; -The resident did not receive nursing oversight at the facility. During interview on 8/28/25 at 3:35 P.M., the Care Coordinator said the following: -He/She was a Level I Medication Aide (LIMA); -He/she completed the pharmacy review with the contracted pharmacist because the facility did not have a nurse to perform this nursing function; -He/She was responsible for reordering resident medications and verifying medications delivered because the facility did not have a nurse; -He/She was responsible for securing signed physician's orders because the facility did not have a nurse; -The facility had been relying on nursing staff	{A4518}			

Missouri Department of Health and Senior Services

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{A4518}	Continued From page 6 from a sister facility to provide assessments; -He/she was concerned that he/she was asked to perform duties within the scope of a licensed or registered nurse. During interview on 8/28/25 at 9:45 A.M., the Executive Director said the facility did not have a nurse and had to rely on nursing services provided by a sister facility for resident assessment and care. *Higher classification merited due to the extent of the violation and the violation's effect on the resident. MO256871 MO257218 MO257563 MO257849 MO258002	{A4518}		
{A4703}	19 CSR 30-86.047(5) Administrator - Licensed The operator shall designate an individual for administrator who is currently licensed as an administrator by the Missouri Board of Nursing Home Administrators, in accordance with Chapter 344, RSMo. II This regulation is not met as evidenced by: This deficiency is uncorrected. For prior examples, please see the Statement of Deficiencies dated 6/24/25. Based on observation and interview, the facility failed to ensure a licensed administrator was employed at the facility as required. The facility census was 12. Observation on 8/28/25 between 9:45 A.M. and 5:09 P.M., showed there was no licensed administrator onsite at the facility. There was no	{A4703}		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/28/2025
NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR OF ST PETERS		STREET ADDRESS, CITY, STATE, ZIP CODE 268 JUNGERMANN ROAD SAINT PETERS, MO 63376			
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{A4703}	Continued From page 7 administrator's license posted at the facility. During interview on 8/28/25, the Executive Director said the following: -The most recent licensed administrator resigned from the facility on 8/7/25 without giving notice; -He had hired a nurse to serve in the position of director of nursing and temporary administrator; -The nurse he had hired worked from 8/15/25 through 8/22/25 and did not return for the scheduled shift on 8/25/25; -The nurse he had hired was not a licensed administrator and had not yet applied for a Temporary Emergency License with the Missouri Board of Nursing Home Administrators; -He was aware regulation required the facility to employ a licensed administrator. MO256871 MO257218 MO257563 MO257849 MO258002	{A4703}			
A4704	19 CSR 30-86.047(6) Operator/Administrator Responsibilities The operator shall be responsible to assure compliance with all applicable laws and regulations. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator ' s responsibilities shall include oversight of residents to assure that they receive care as defined in the individualized service plan. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility	A4704			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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A4704	Continued From page 8 operator failed to follow all applicable regulations when they operated the facility without an appropriately trained and licensed administrator and without a qualified nurse. The facility census was 12. 1. Record review of administration records on 8/28/25 showed the following: - The facility hired an individual with the intention of requesting a Temporary Emergency License who worked from 8/15/25 through 8/22/25 and did not return to work for a scheduled shift on 8/25/25; - During onsite investigation on 8/28/25, the facility did not have a licensed administrator. On 8/28/25 at 9:45 A.M., the Executive Director said that he was aware the facility was required to have a licensed administrator. 2. Record review of nursing records on 8/28/25 showed the following: - The Director of Nursing/Administrator E resigned on 8/7/25; - The facility hired a nurse to serve in the dual-role of Director of Nursing/Administrator F who worked from 8/15/25 to 8/22/25 and did not return for a scheduled shift on 8/25/25; - During onsite investigation on 8/28/25, the facility did not employ a licensed or registered nurse to provide for resident needs for assessment and care. On 8/28/25 at 9:45 A.M., the Executive Director said he was aware the facility was required to have a licensed or registered nurse to provide resident assessment and care. 3. During interview on 8/28/25 between 9:45 A.M. and 5:09 P.M., the Executive Director said the	A4704		

Missouri Department of Health and Senior Services

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HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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A4704	Continued From page 9 following: - It had been the corporate intention to utilize one employee in the dual-capacity of Director of Nursing and Administrator; - This dual-role had been a difficult position to fill and maintain; - The owner had made the decision to separate the positions in order to find appropriate candidates. *The higher classification merited due to extent of violation	A4704		
A4748	19 CSR 30-86.047(28)(E) Premove-in Screening Requirements The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (E) The premove-in screening shall be completed prior to admission with the participation of the prospective resident and be designed to determine if the individual is eligible for admission to the assisted living facility and shall be based on the admission restrictions listed at section (29) of this rule; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to complete a premove-in screening prior to admission with the participation of the prospective resident and designed to determine if the individual is eligible for admission two residents (Residents #4 and #8) of 12 sampled residents. The facility census was 12. 1. Review of Resident #4's facility medical record	A4748		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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A4748	Continued From page 10 showed the following: -Admission on 8/7/25; -Diagnoses included hypertension, coronary artery disease (heart disorder), congestive heart failure (heart disorder), hyperlipidemia, glaucoma (vision disorder), osteoarthritis (bone and joint disease), mild dementia (disorder of that affects thought processes and memory), depression (mental illness characterized by persistent sadness), neuropathy (nerve disorder causing pain and numbness in the arms or legs), and lumbar stenosis (spine disorder that affects nerves and movement); - No screening prior to admission with the participation of the prospective resident and designed to determine if the individual was eligible for admission to the assisted living facility. 2. Review of Resident #8's facility medical record showed the following: - Admission on 8/27/25; - Diagnoses included hyperlipidemia, gout (disorder which affects joints, particular the toes), Parkinson's Disease (nerve disorder which affects movement), gastroesophageal reflux disease (GERD)(digestive disorder), benign prostatic hyperplasia (enlargement of the prostate gland that causes urinary symptoms), osteoarthritis, major depressive disorder (mental illness characterized by persistent sadness), and acute cardiac syndrome (combination of conditions which reduces the blood flow to the heart); -No screening prior to admission with the participation of the prospective resident and designed to determine if the individual was eligible for admission to the assisted living facility. 3. During interviews on 8/28/25 at 9:45 A.M. and 5:09 P.M., the Executive Director said the	A4748		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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A4748	Continued From page 11 following: -The facility currently relied on trained staff from a sister facility to complete premove-in screenings on all new residents; - He was not aware two residents admitted since the previous director of nursing/administrator left did not have premove-in screening in their records.	A4748		
A4749	19 CSR 30-86.047(28)(F)(1)(A) Community Based Assessment-Time Period, 5 day The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (F) Completes a community based assessment conducted by an appropriately trained and qualified individual as defined in section (4) of this rule: 1. Time frame requirements for assessment shall be: A. Within five (5) calendar days of admission; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure a community based assessment (CBA, document which identified the resident's abilities, needs, and limitations) was completed by an appropriately trained and qualified individual within five days of admission for one resident (Residents #4) of 12 sampled residents. The facility census was 12. 1. Review of Resident #4's electronic medical record dashboard showed the following: -Admission on 8/7/25; -Diagnoses included hypertension, coronary	A4749		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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**268 JUNGERMANN ROAD
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A4749	Continued From page 12 artery disease (heart disorder), congestive heart failure (heart disorder), hyperlipidemia, glaucoma (vision disorder), osteoarthritis (bone and joint disease), mild dementia (disorder of that affects thought processes and memory), depression (mental illness characterized by persistent sadness), neuropathy (nerve disorder causing pain and numbness in the arms or legs), and lumbar stenosis (spine disorder that affects nerves and movement); - No CBA in the electronic or physical medical file showing an assessment of resident's abilities conducted by a appropriately trained and qualified individual within five days of admission to the facility. During interviews on 8/28/25 at 9:45 A.M. and 5:09 P.M., the Executive Director said the following: -The facility was currently relying on trained staff from a sister facility to complete CBAs on all new residents; -He was not aware the resident did not have a CBA in their physical or electronic records.	A4749		
A4751	19 CSR 30-86.047(28)(F)(1)(C) Community Based Assessment-Significant Change The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (F) Completes a community based assessment conducted by an appropriately trained and qualified individual as defined in section (4) of this rule: 1. Time frame requirements for assessment shall be:	A4751		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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A4751	Continued From page 13 C. Whenever a significant change has occurred in the resident ' s condition, which may require a change in services. II This regulation is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a community based assessment (CBA, document which identified the resident's abilities, needs, and limitations) was completed by an appropriately trained and qualified individual when a significant change in condition occurred in the resident's condition and required a change in services for two residents (Residents #1 and #6) of 12 sampled residents. The facility census was 12. 1. Review of Resident #1's electronic medical record dashboard showed the following: -Admission on 8/1/25; -Diagnoses included acute respiratory failure (breathing disorder), chronic obstructive pulmonary disease (COPD)(breathing disorder), history of lung and brain cancer, and cognitive communication deficit (problem with speech and language comprehension);. Review of the resident's CBA dated 8/1/25 showed the resident required assistance with walking/mobility and used a wheelchair as an assistive device for mobility. Observation of the resident on 8/28/25 showed the following: -The resident's wheelchair was in an adjacent room and inaccessible to the resident; -Hospice staff present and assisting the resident with personal cares; -The resident was unresponsive to verbal communication.	A4751		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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A4751	Continued From page 14 During interview on 8/28/25, the Care Coordinator said the resident had been admitted to hospice care through an outside agency on 8/26/25. Review of the resident's CBA showed it had not been updated to reflect the resident received hospice care 2. Record review of Resident #6's electronic medical record dashboard on 8/28/25 showed the following: -Admission on 2/15/25; -Diagnoses included hypertension (high blood pressure), chronic kidney disease (disorder which reduces the kidney's ability to filter waste from the blood), congestive heart failure (disorder in which the heart is unable to efficiently pump blood throughout the body), atrial fibrillation (heart disorder characterized by a rapid, chaotic heart beat), and peripheral vascular disease (narrowing or blockage of blood vessels). Review of the resident's CBA dated 2/6/25 showed the resident had been admitted to hospice, spent most of his/her time in bed and required the assistance of two staff for transfers. Review of the resident's progress note dated 8/7/25, showed the resident had fallen while self-transferring from the bed to the wheelchair because the resident had not locked the wheelchair wheel. Review of the resident's progress notes showed the resident was discharged by the hospice provider on 8/26/25 because he/she no longer met the criteria for hospice services. Observation of the resident on 8/28/25 at 2:15 P.M., showed the resident at the dining room	A4751			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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A4751	Continued From page 15 table in a wheelchair playing a dice game with other residents and activity staff. During interview on 8/28/25, the Care Coordinator said the following: -The resident has been able to build up sufficient strength and confidence to self-transfer from bed to wheelchair and self-ambulate to the dining room at will; -The resident fell on 8/7/25 when self-transferring, but had been transferring from bed to wheelchair and back without assistance both before and after the fall; -The resident discharged from hospice on 8/26/25 due to no longer meeting criteria for hospice services. Review of the resident's CBA showed it had not been updated to reflect the resident improved and was no longer on hospice. 3. During interviews on 8/28/25 at 9:45 A.M. and 5:09 P.M., the Executive Director said the following: -The facility currently relied on trained staff from a sister facility to complete CBAs on residents who experienced a change in condition; -He was not aware the residents who had a change in condition did not have updates made to their CBAs.	A4751			
A4754	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility:	A4754			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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A4754	Continued From page 16 (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident ' s needs and preferences, services to be provided, and goals expected by the resident or the resident ' s legal representative in partnership with the facility; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to develop an individualized service plan (ISP, the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and the goals expected by the resident or the resident's legal representative in partnership with the facility) for two residents (Residents #4 and #8) of 12 sampled residents. The facility census was 12. 1. Review of Resident #4's electronic medical records dashboard showed the following: -Admission on 8/7/25; -Diagnoses included hypertension, coronary artery disease (heart disorder), congestive heart failure (heart disorder), hyperlipidemia, glaucoma (vision disorder), osteoarthritis (bone and joint disease), mild dementia (disorder of that affects thought processes and memory), depression (mental illness characterized by persistent sadness), neuropathy (nerve disorder causing pain and numbness in the arms or legs), and lumber stenosis (spine disorder that affects nerves and movement). Review of the resident's facility medical record showed no ISP for the resident. 2. Review of Resident #8's electronic medical record dashboard showed the following:	A4754			

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/28/2025
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A4754	Continued From page 17 -Admission on 8/27/25; -Diagnoses included hyperlipidemia, gout (disorder which affects joints, particular the toes), Parkinson's Disease (nerve disorder which affects movement), gastroesophageal reflux disease (GERD)(digestive disorder), benign prostatic hyperplasia (enlargement of the prostate gland that causes urinary symptoms), osteoarthritis, major depressive disorder (mental illness characterized by persistent sadness), and acute cardiac syndrome (combination of conditions which reduces the blood flow to the heart). Review of the resident's facility record showed no ISP for the resident. 3. During interviews on 8/28/25 at 9:45 A.M. and 5:09 P.M., the Executive Director said the following: -The facility currently relied on trained staff from a sister facility to complete ISPs on all new residents; -He was not aware residents admitted since the previous director of nursing/administrator left did not have ISPs in their records.	A4754		
A4755	19 CSR 30-86.047(28)(H) Individual Service Plan - Review Requirements The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (H) Reviews the ISP with the resident, or legal representative of the resident, at least annually or when there is a significant change in the resident 's condition which may require a change in	A4755		

Missouri Department of Health and Senior Services

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A4755	Continued From page 18 services; II This regulation is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensures staff reviewed all individualized service plans (ISP, the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and the goals expected by the resident or the resident's legal representative in partnership with the facility) when there was a significant change in the resident's condition which may require a change in services for two residents (Residents #1 and #6) of 12 residents selected for review. The facility census was 12. 1. Review of Resident #1's electronic medical record dashboard showed the following: -Admission on 8/1/25; -Diagnoses included acute respiratory failure (breathing disorder), chronic obstructive pulmonary disease (COPD)(breathing disorder), history of brain and lung cancer, and cognitive communication deficit (problem with speech and language comprehension). Review of the resident's ISP dated 8/1/25 showed the resident required assistance with walking/mobility and used a wheelchair as an assistive device for mobility. Observation of the resident on 8/28/25 at 3:07 P.M. showed the following: -The resident's wheelchair was in an adjacent room and inaccessible to the resident; -Hospice staff present and assisting the resident with personal cares; -The resident was unresponsive to verbal communication.	A4755			

Missouri Department of Health and Senior Services

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A4755	Continued From page 19 During interview on 8/28/25 at 12:11 P.M., the Care Coordinator said the resident had been admitted to hospice care through an outside agency on 8/26/25. Review showed the resident's ISP had not been updated to reflect the resident recieved hospice care. 2. Record review of Resident #6's electronic medical records dashboard on 8/28/25 showed the following: -Admission on 2/15/25; -Diagnoses included hypertension (high blood pressure), chronic kidney disease (disorder which reduces the kidney's ability to filter waste from the blood), congestive heart failure (disorder in which the heart is unable to efficiently pump blood throughout the body), atrial fibrillation (heart disorder characterized by a rapid, chaotic heart beat), and peripheral vascular disease (narrowing or blockage of blood vessels). Review of the resident's ISP dated 6/24/25 showed the following: -The resident was bed-bound, could no longer bear weight for transfers, and needed to be taken to a safe location by staff during an emergency; -The ISP did not specify the number of staff necessary to transfer the resident; -The ISP did not include an individualized evacuation plan for this resident. Review of the resident's progress note dated 8/7/25, showed the resident had fallen while self-transferring from the bed to the wheelchair because the resident had not locked the wheelchair wheel.	A4755			

Missouri Department of Health and Senior Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A4755	Continued From page 20 Review of the resident's progress notes showed the resident was discharged by the hospice provider on 8/26/25 because he/she no longer met the criteria for hospice services. Observation of the resident on 8/28/25 at 2:15 P.M. showed the resident at the dining room table in a in a wheelchair playing a dice game with other residents and activity staff. During interview on 8/28/25, the Care Coordinator said the following: -The resident has been able to build up sufficient strength and confidence to self-transfer from bed to wheelchair and self-ambulate to the dining room at will; -The resident fell on 8/7/25 when self-transferring, but had been transferring from bed to wheelchair and back without assistance both before and after the fall; -The resident discharged from hospice on 8/26/25 due to no longer meeting criteria for hospice services. 3. During interviews on 8/28/25 at 9:45 A.M. and 5:09 P.M., the Executive Director said the following: - The facility had previously relied on the director of nursing/administrator to complete the ISP when there was a change in condition; - The facility was currently relying on trained staff from a sister facility to complete ISPs on residents who experienced a change in condition; - He was not aware the residents who had a change in condition did not have updated ISPs in their physical or electronic records.	A4755			
A4780	19 CSR 30-86.047(39) Unsealed Medications - Identify	A4780			

Missouri Department of Health and Senior Services

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A4780	Continued From page 21 If the resident brings unsealed medications to the facility, the medications shall not be used unless a pharmacist, physician or nurse examines, identifies and determines the contents to be suitable for use. The person performing the identification shall document his or her review. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview, and record review, the facility failed to ensure unsealed medications brought to the facility by a resident or resident family were not used unless a pharmacist, physician, or nurse examined, identified and determined the contents to be suitable for use for one resident (Resident #8) of 12 sampled residents. The facility census was 12. 1. Review of Resident #8's electronic medical records dashboard showed the following: -Admission on 8/27/25; -Diagnoses included hyperlipidemia, gout (disorder which affects joints, particular the toes), Parkinson's Disease (nerve disorder which affects movement), gastroesophageal reflux disease (digestive disorder), benign prostatic hyperplasia (enlargement of the prostate gland that causes urinary symptoms), osteoarthritis, major depressive disorder (mental illness characterized by persistent sadness), and acute cardiac syndrome (combination of conditions which reduces the blood flow to the heart); Review of resident's physicians orders from the admission physical signed by resident's primary physician dated 8/21/25 showed the following medication orders:	A4780		

Missouri Department of Health and Senior Services

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A4780	Continued From page 22 -Sinemet (medication to treat Parkinson's Disease), 25-100 milligrams (mg), 1 tablet at 6:30 A.M., 1 tablet at 12:30 P.M., and 2 tablets at 6:30 P.M. per day; -Colace (medication to treat constipation), 100 mg, 1 tablet two times per day; -Remeron (anti depressant), 7.5 mg, one tablet daily at night; -Multivitamin tablet, one tablet per day; -Miralax (medication to treat constipation), 17 grams (gm), one packet of powder dissolved in liquid daily as needed; -Flomax (medication to treat prostate disease), 0.4 mg, one capsule by mouth daily. Review of the resident's paper and electronic facility records showed no Medication Administration Record (MAR) documenting administration of medication by facility staff on 8/27/25 or 8/28/25. Observation of the nurse's station on 8/28/25 showed the following: -A seven day blue pill organizer for seven days with four administration times per day, labeled with Resident #8's name and room number; -The morning section for Saturday contained seven medications including one large round white tablet, one small round yellow tablet, one medium round white tablet, one tan small square tablet, one medium blue oblong tablet, one medium round tablet with the letter E, and one unidentified tablet; -The noon section for Saturday contained two medications including one oblong blue tablet and one-half of a large round white tablet; -The evening section for Saturday was empty; -The bedtime section for Saturday contained five medications including one large round white tablet, one medium oblong blue tablet, one small	A4780		

Missouri Department of Health and Senior Services

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A4780	Continued From page 23 white oblong tablet, one medium round white tablet, and one half of a large round white tablet. During interview on 8/28/25, the Care Coordinator said the following: -The resident admitted to the facility on the evening of 8/27/25 from home; -The resident brought medications from home in a pill organizer box; -The medications the resident arrived with were not in bottles with labels; -The resident's family administered the resident's medications from the pill organizer on the evening of 8/27/25 during the move-in process; -Facility staff administered the resident's medications from the pill organizer on the morning of 8/28/25; -The facility did not have a nurse to verify the medications in the pill organizer matched the physician orders on the admission physical; -The Care Coordinator instructed staff to administer the medications from the pill organizer based on the family statement the pills were organized according to the physician's orders and the concern that the resident could have a negative consequence from not receiving his/her medications on schedule; -The Care Coordinator was not a nurse, was a Level One Medication Aide (LIMA), and had no training to verify the medications in the pill organizer matched physician orders. During interview on 8/28/25 at 5:09 P.M., the Executive Director said he was not aware staff administered unlabeled medications to a newly admitted resident. *The higher classification merited due to the impact when combined with other deficiencies.	A4780		

Missouri Department of Health and Senior Services

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A4809	Continued From page 24	A4809		
A4809	19 CSR 30-86.047(47)(G) Medication Administration, Documented Medication Orders. (G) The administration of medication shall be recorded on a medication sheet or directly in the resident 's record and, if recorded on a medication sheet, shall be made part of the resident 's record. The administration shall be recorded by the same individual who prepares the medication and administers it. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to ensure administration of medication was recorded on a medication administration record (MAR) sheet or an electronic medication administration record (eMAR) as part of the resident's record by the same individual who prepared and administered the medication for one resident (Resident #8) of 12 sampled residents. The facility census was 12. 1. Review of Resident #8's electronic medical records dashboard showed the following: -Admission on 8/27/25; -Diagnoses included hyperlipidemia, gout (disorder which affects joints, particular the toes), Parkinson's Disease (nerve disorder which affects movement), gastroesophageal reflux disease (digestive disorder), benign prostatic hyperplasia (enlargement of the prostate gland that causes urinary symptoms), osteoarthritis, major depressive disorder (mental illness characterized by persistent sadness), and acute cardiac syndrome (combination of conditions which reduces the blood flow to the heart);	A4809		

Missouri Department of Health and Senior Services

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A4809	Continued From page 25 Review of the resident's physician orders from the admission physical signed by resident's primary physician dated 8/21/25, showed the following medication orders: -Sinemet (medication to treat Parkinson's Disease), 25-100 milligrams (mg), 1 tablet at 6:30 A.M., 1 tablet at 12:30 P.M., and 2 tablets at 6:30 P.M. per day; -Colace (medication to treat constipation), 100 mg, 1 tablet two times per day; -Remeron (antidepressant), 7.5 mg, one tablet daily at night; -Multivitamin tablet, one tablet per day; -Miralax (medication to treat constipation), 17 grams (gm), one packet of powder dissolved in liquid daily as needed; -Flomax (medication to treat prostate disease), 0.4 mg, one capsule by mouth daily. Review of the resident's paper and electronic records showed no medication administration record (MAR) documenting administration of medication by facility staff on 8/27/25 or 8/28/25. During interview on 8/28/25, the Care Coordinator said the following: -The resident was admitted to the facility on the evening of 8/27/25 from home; -The resident brought his/her medications from home in a pill organizer box; -The resident's family administered the resident's medications from the pill organizer on the evening of 8/27/25 during the move-in process; -Facility staff had administered the resident's medications from the pill organizer on the morning of 8/28/25; -The Care Coordinator did not have access in the electronic medication administration record (eMAR) to add the prescribed medication to the	A4809		

Missouri Department of Health and Senior Services

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A4809	Continued From page 26 system so that care staff could electronically document administration of the resident's medications; -The Care Coordinator did not have access in the eMAR to print a blank MAR for the resident and therefore the staff had not documented administration of the resident's medications on 8/27/25 or 8/28/25. During interview on 8/28/25 at 5:09 P.M., the Executive Director said he was not aware staff had administered unlabeled medications to a newly admitted resident and had not documented the administration of the medication either on paper or electronically. *The higher classification merited due to impact when combined with other deficiencies.	A4809			
{A4837}	19 CSR 30-86.047(58)(B) Resident Condition/Medication Review The facility shall maintain a record in the facility for each resident, which shall include the following: (B) A review monthly or more frequently, if indicated, of the resident ' s general condition and needs; a monthly review of medication consumption of any resident controlling his or her own medication, noting if prescription medications are being used in appropriate quantities; a daily record of administration of medication; a logging of the medication regimen review process; a monthly weight; a record of each referral of a resident for services from an outside service; and a record of any resident incidents including behaviors that present a reasonable likelihood of serious harm to himself or herself or others and accidents that potentially	{A4837}			

Missouri Department of Health and Senior Services

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{A4837}	Continued From page 27 could result in injury or did result in injuries involving the resident; III This regulation is not met as evidenced by: This deficiency is uncorrected. For prior examples, please see Statement of Deficiencies dated 6/24/25. Based on interview and record review, the facility failed to ensure a monthly weight and resident condition review was completed for seven residents (Residents #3, #5, #6, #7, #9, #11, and #12) of 12 sampled residents. The facility census was 12. 1. Review of Resident #3's record showed the following: - Admission date 4/1/25; - No monthly review of resident's weight and condition for June and July, 2025. Review of Resident #5's record showed the following: - Admission date 1/30/25; - No monthly review of resident's weight and condition for June and July, 2025. Review of Resident #6's record showed the following: - Admission date 2/15/25; - No monthly review of resident's weight and condition for June and July, 2025. Review of Resident #7's record showed the following: - Admission date 2/28/25; - No monthly review of resident's weight and condition for June and July, 2025.	{A4837}			

Missouri Department of Health and Senior Services

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{A4837}	Continued From page 28 Review of Resident #9's record showed the following: - Admission date 5/1/25; - No monthly review of resident's weight and condition for June and July, 2025. Review of Resident #11's record showed the following: - Admission date 12/20/24; - No monthly review of resident's weight and condition for June and July, 2025. Review of Resident #12's record showed the following: - Admission date 2/6/25; - No monthly review of resident's weight and condition for June and July, 2025. 2. During interview on 8/28/25, the Care Coordinator said the following: -The director of nursing/administrator had been responsible for completing the monthly resident weights and condition review; -He/She did not feel properly trained to complete a monthly review without guidance from a nurse. During interviews on 8/28/25 at 9:45 A.M. and 5:09 P.M., the Executive Director said the following: - The facility relied on the director of nursing/administrator to complete the monthly resident weight and condition review; - He was not aware the monthly reviews had not been completed for June and July, 2025.	{A4837}		

Hampton Manor of St. Peters - Plan of Correction

Facility: Hampton Manor of St. Peters

Address: 268 Jungermann Road, Saint Peters, MO 63376

Survey Date: August 28, 2025

Individualized Evacuation Plans - Tag A4512

Deficiency	Failed to ensure residents needing more than minimal assistance had individualized evacuation plans and staff training.
Corrective Action Taken	Immediate individualized evacuation plans (IEPs) developed for resident #4. Resident #1 discharged 8/30/25. All staff instructed on evacuation responsibilities.
Systemic Changes	All current residents assessed, IEPs created and filed. Policy updated requiring IEP completion on admission. Training conducted for all direct care staff.
Monitoring/QA Plan	Monthly audits of resident records and quarterly evacuation drills to ensure IEPs are current and staff are knowledgeable.
Responsible Party	Administrator / DON
Completion Date	9/10/2025

Staffing – Licensed Nurse - Tag A4518

Deficiency	Facility operated without a licensed nurse.
Corrective Action Taken	Licensed nurse hired 9/9/25 to serve as Director of Nursing
Systemic Changes	Facility will follow staffing guidelines, to include Licensed Nurse requirements, outlined in CSR 30-86.045
Completion Date	9/9/25

Administrator - Licensed - Tag A4703

Deficiency	Facility operated without a licensed administrator.
Corrective Action Taken	Licensed Administrator hired 9/11/25.
Systemic Changes	Change of Administrator submitted on 9/16/25. License is posted in the lobby.

	Facility will follow guidelines outlined in CSR 30-86.047(5)
Completion Date	9/16/25

Operator/Administrator Responsibilities - Tag A4704

Deficiency	Facility operated without a licensed administrator.
Corrective Action Taken	Licensed Administrator hired 9/11/25.
Systemic Changes	Change of Administrator submitted on 9/16/25. License is posted in the lobby. Facility will follow guidelines outlined in CSR 30-86.047(6), empowering administrator to make decisions regarding the operation of the facility.
Completion Date	9/16/25

Premove-in Screening Requirements - Tag A4748

Deficiency	Failed to complete premove-in screenings prior to admission for residents #4 and #8.
Corrective Action Taken	Screenings completed immediately for residents #4 and #8 and all others lacking documentation. Admissions halted until screenings verified. DON is qualified to perform CBA and will screen all potential admissions.
Systemic Changes	Admissions checklist updated to require screening completion prior to move-in. Admin staff trained on admission compliance requirements. Admin staff trained on requirement to conduct CBAs within 5 days of admission by qualified staff. Admissions coordinator trained on requirement.
Monitoring/QA Plan	Monthly audit of new admissions for 90 days; monthly thereafter.
Responsible Party	Administrator
Completion Date	9/25/2025

Community Based Assessment Time Period, 5 day - Tag A4749

Deficiency	Failed to complete CBA prior to admission for residents #4.
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Corrective Action Taken	Screening completed immediately for resident, and for all others lacking documentation. Admissions halted until screenings verified. DON is qualified to perform CBA and will screen all potential admissions within 5 days of move-in.
Systemic Changes	Admissions checklist updated to require screening completion prior to move-in. Admin staff trained on admission compliance requirements. Admin staff trained on requirement to conduct CBAs within 5 days of admission by qualified staff.
Monitoring/QA Plan	Monthly audit of new admissions for 90 days; monthly thereafter.
Responsible Party	Administrator
Completion Date	9/25/2025

CBA Update after Significant Change - Tag A4751

Deficiency	Failed to update CBAs when residents had significant changes in condition (Residents #1 and #6).
Corrective Action Taken	CBA updated immediately for resident #6. Resident #1 discharged 8/30/25. CBAs updated immediately to reflect current conditions and hospice status.
Systemic Changes	Care staff trained to notify DON immediately of changes.
Monitoring/QA Plan	Weekly change-in-condition report audits for 90 days.
Responsible Party	DON
Completion Date	9/25/25

Development of Individualized Service Plan (ISP) - Tag A4754

Deficiency	Failed to develop ISPs for residents #4 and #8.
Corrective Action Taken	ISPs developed immediately for residents #4 and #8.
Systemic Changes	Admissions process revised to ensure ISP is completed within 5 days of admission. Training conducted for admissions and care staff.

Monitoring/QA Plan	Monthly ISP audits conducted for new admissions.
Responsible Party	DON / Administrator
Completion Date	9/24/25

ISP Review Requirements - Tag A4755

Deficiency	Failed to review and update ISPs upon significant change in condition for Residents #1 and #6.
Corrective Action Taken	ISP developed for resident #6. Resident #1 discharged 8/30/25.
Systemic Changes	Policy revised to require ISP reviews upon any significant change and annually. Care staff trained to notify DON immediately of changes.
Monitoring/QA Plan	Quarterly ISP audits conducted by DON.
Responsible Party	DON
Completion Date	9/25/2025

Unsealed/Unlabeled Medications - Tag A4780

Deficiency	Unsealed medications from resident/family used without pharmacist/nurse verification.
Corrective Action Taken	Reconciled medications with pharmacy for resident #8 to ensure proper medications are administered. Strip packaging is correct and medications are being documented in EMAR.
Systemic Changes	Educated care staff on not accepting unsealed/unlabeled medications without assessment of medications.
Monitoring/QA Plan	Random med audits weekly for 60 days, then monthly.
Responsible Party	DON
Completion Date	10/7/2025

Medication Administration Documentation - Tag A4809

Deficiency	Failed to document medication administration on MAR/eMAR for Resident #8.
Corrective Action Taken	MAR updated for Resident #8. Staff counseled.
Systemic Changes	Staff retrained on MAR/eMAR procedures.
Monitoring/QA Plan	Weekly MAR audits for 90 days, then

	monthly.
Responsible Party	DON
Completion Date	9/24/25

Resident Condition/Medication Review - Tag A4837

Deficiency	Failed to complete monthly weights and condition monitoring as required.
Corrective Action Taken	Weights and reviews completed for resident #3, #6, #7, #9, #11, and #12. Resident #5 discharged on 8/29/25.
Systemic Changes	DON and RCC will conduct monthly reviews of all residents' medication regimen and general condition. Staff retrained on reporting change of condition.
Monitoring/QA Plan	Monthly audits of weights, medication regimen, general condition and documentation of any change in condition, weekly for 90 days, then monthly.
Responsible Party	DON / Resident Care Coordinator
Completion Date	9/24/25

Missouri Department of Health and Senior Services

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{A4512}	19 CSR 30-86.045(3)(A)(10) Comply with All Req.of Section (3) of rule General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 10. Comply with all requirements of this rule. I/II This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated 8/28/25. Class II Based on observation, interview, and record review, the facility failed to ensure residents who needed more than minimal assistance due to physical or cognitive impairments had an individualized evacuation plan (IEP) in the resident's individual service plan (ISP), the IEP listed the responsibilities of specific staff positions in an emergency specific to the individual, the IEP included specific interventions needed to ensure the safety of the resident, the IEP included the resident's location within the facility including proximity to exits and areas of refuge and risk of resistance, mobility, and need for additional staff support, that employees with specific responsibilities received training regarding their duties and responsibilities under the resident's evacuation plan, and the written IEP be readily available to all staff for one resident (Resident #4) who required assistance of two staff to transfer of 12 sampled residents. The facility census was 12. The facility did not provide a policy for IEPs upon	{A4512}			

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

4EZB13

If continuation sheet 1 of 25

Missouri Department of Health and Senior Services

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SAINT PETERS, MO 63376**

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{A4512}	19 CSR 30-86.045(3)(A)(10) Comply with All Req.of Section (3) of rule General Requirements. (A) If the facility admits or retains any individual needing more than minimal assistance due to having a physical, cognitive or other impairment that prevents the individual from safely evacuating the facility, the facility shall: 10. Comply with all requirements of this rule. I/II This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated 8/28/25. Class II Based on observation, interview, and record review, the facility failed to ensure residents who needed more than minimal assistance due to physical or cognitive impairments had an individualized evacuation plan (IEP) in the resident's individual service plan (ISP), the IEP listed the responsibilities of specific staff positions in an emergency specific to the individual, the IEP included specific interventions needed to ensure the safety of the resident, the IEP included the resident's location within the facility including proximity to exits and areas of refuge and risk of resistance, mobility, and need for additional staff support, that employees with specific responsibilities received training regarding their duties and responsibilities under the resident's evacuation plan, and the written IEP be readily available to all staff for one resident (Resident #4) who required assistance of two staff to transfer of 12 sampled residents. The facility census was 12. The facility did not provide a policy for IEPs upon	{A4512}		

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 10/29/2025
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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{A4512}	Continued From page 1 request. 1. Review of Resident #4's medical record on 10/9/25 showed the resident admitted on 2/15/25 with diagnosis of essential hypertension (high blood pressure). Review of the resident's Community Based Assessment (CBA- a mandatory evaluation for residents of assisted living facilities. Performed by a qualified individual who has completed specific training, this assessment documents a person's needs related to daily living, health, social participation, and cognitive functioning) in the residents electronic medical record (EMR) dated 5/5/25 on 10/15/25 showed the resident required two staff to assist for transfer on a regular basis. Review of the resident's CBA located in the resident's EMR dated 7/7/25 on 10/15/25 showed the following: -Ambulation: staff assists regularly due to physical needs or confusion; -Transfers: needs physical assistance for transfers on a regular basis, able to bear weight during transfers. Review of the resident's ISP (a personalized care plan created for a resident. It outlines the specific services, support, and personal goals needed to maintain the resident's health, safety, and well-being) located in the resident's EMR dated 7/7/25 on 10/15/25 showed the following: -Transfer: able to bear weight and transfer from bed to wheelchair and to bed with assistance of one caregiver; -Mobility: propel in wheelchair to location of choice. Unable to propel self; -Response to emergency: resident requires assistance of one caregiver to transfer from bed	{A4512}		

Missouri Department of Health and Senior Services

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{A4512}	Continued From page 2 to chair and propel in wheelchair to nearest area of refuge. Review of the resident's electronic medical record showed no IEP on file. During an interview on 10/9/25 at 11:30 A.M., Level One Medication Aide (LIMA) H and LIMA J said the following: -IEPs are kept in a binder located at the nurses station on the assisted living side of the facility; -They do not have access to the portion of a resident's electronic medical record where IEPs were documented. Observation of an unlabeled binder located at the nurses station showed it did not include an IEP for Resident #4. During an interview on 10/9/25 at 11:30 A.M., LIMA H said the following: -There were two residents who needed help with transfers and propelling their wheelchairs. One resident had an IEP but Resident #4 did not; -Resident #4 required assistance to transfer and will not propel his/her wheelchair; -Resident #4 would need staff assistance to evacuate in an emergency. During an interview on 10/9/25 at 12:30 P.M., LIMA J said the following: -Resident #4 does not bear any weight, staff have to physically transfer the resident from the bed to the chair and the chair to the bed; -The resident cannot propel the wheelchair, staff would have to assist the resident if there was an emergency. During an interview on 10/9/25, LIMA E said the following:	{A4512}		

Missouri Department of Health and Senior Services

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HAMPTON MANOR OF ST PETERS

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{A4512}	Continued From page 3 -There were two residents who need assistance with transfers, one was Resident #4. -Resident #4 cannot propel his/herself in the wheelchair, staff have to push him/her; -He/She did not know where IEPs were kept. Observation on 10/9/25 at 5:30 P.M. showed staff pushed Resident #4 in a wheelchair from his/her room to the dining room. During an interview on 10/9/25 at 5:30 P.M., Resident #4 said the following: -He/She could bear some weight, but was not able to transfer by him/herself. Staff must push him/her in the wheelchair as he/she was too weak to propel the chair; -Staff would have to help him/her evacuate if there was an emergency. During an interview on 10/9/25 at 12:15 P.M., the Director of Nursing said the following: -IEPs were kept in a binder at the nurses station; -When the DON assessed Resident #4, he/she did not need an IEP because the resident can transfer him/herself and propel their own wheelchair. She was not aware the resident could no longer propel his/her own wheelchair and needed more help from the staff. During an interview on 10/9/25 at 7:30 P.M., the Administrator said the following: -The IEP should be completed upon admission and if there was a change of condition; -The IEP should explain to staff how to assist the resident if there was a need to evacuate; -The IEP should be readily accessible to the staff; -Staff should have access to the residents electronic medical record and the IEP should be kept in a binder at the nurses station; -He understood all of the IEPs were complete,	{A4512}		

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER HAMPTON MANOR OF ST PETERS			STREET ADDRESS, CITY, STATE, ZIP CODE 268 JUNGERMANN ROAD SAINT PETERS, MO 63376		
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{A4512}	Continued From page 4 current and available to staff.	{A4512}			
A4711	19 CSR 30-86.047(13)(A) Criminal Background Check Requirements Prior to allowing any person who has been hired in a full-time, part-time, or temporary position to have contact with any resident, the facility shall, or in the case of temporary employees hired through or contracted from an employment agency, the employment agency shall, prior to sending a temporary employee to a facility: (A) Request a criminal background check for the person, as provided in section 660.317, RSMo. Each facility shall maintain documents verifying that the background checks were requested, the date of each such request, and the nature of the response received for each such request. II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to secure a criminal background check for all newly hired employees prior to the employee having resident contact for five of ten sampled employees (Administrator, Director of Nursing, Receptionist, Maintenance Director and Level One Medication Aide (LIMA) F). The facility census was 12. The facility did not provide a policy for Criminal Background Checks for new employees upon request. 1. Review the Administrator's personnel file showed the following: -Hire date of 9/11/25; -First date of contact with residents was 9/11/25; -No documentation of a criminal background	A4711			

Missouri Department of Health and Senior Services

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A4711	Continued From page 5 check or request for the check. 2. Review of the Director of Nursing's personnel file showed the following: -Hire date of 9/9/25; -First date of contact with residents 9/9/25: -No documentation of a criminal background check or request for the check. 3. Review of the Maintenance Director's personnel file showed the following: -Hire date of 8/21/25; -First date of contact with residents was 9/9/25: -No documentation of a criminal background check or request for the check. 4. Review of LIMA F's personnel file showed the following: -Hire date of 9/3/25; -First date of contact with residents 8/27/25: -No documentation of a criminal background check or request for the check. 5. Review of the Receptionist's personnel file showed the following: -Hire date of 8/20/25; -First date of contact with the residents 8/13/25; -No documentation of a criminal background check or request for the check. During an interview on 10/9/25, the Administrator said the following: -A criminal background check should be completed before the employee has contact with the residents. -He thought the administrator at a sister facility completed the criminal background checks on himself and the DON, he did not know why they were not done; -The Administrator should complete the	A4711		

Missouri Department of Health and Senior Services

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A4711	Continued From page 6 background checks or verify that they were done prior to the employee beginning work. MO258458	A4711		
A4714	19 CSR 30-86.047(13)(B) EDL Inquiry Prior to allowing any person who has been hired in a full-time, part-time, or temporary position to have contact with any resident, the facility shall, or in the case of temporary employees hired through or contracted from an employment agency, the employment agency shall, prior to sending a temporary employee to a facility: (B) Make an inquiry to the department, as provided in section 660.315, RSMo, as to whether the person is listed on the EDL. Each facility shall maintain documents verifying that the EDL checks were requested, the date of each such request, and the nature of the response received for each such request. The inquiry may be made through the department ' s website; II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility failed to make an inquiry to the department whether a person was listed on the Employee Disqualification List (EDL) and document such requests, prior to allowing seven of ten sampled employees (Administrator, Director of Nursing, Maintenance Director, Receptionist, Level One Medication Aide (LIMA) A, LIMA B, and LIMA F) to have contact with residents. The facility census was 12. The facility did not provide a policy regarding EDL	A4714		

Missouri Department of Health and Senior Services

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A4714	Continued From page 7 checks upon request. 1. Review the Administrator's personnel file showed the following: -Hire date of 9/11/25; -First date of contact with residents was 9/11/25; -No documentation of an EDL or request for the EDL. 2. Review of the Director of Nursing's personnel file showed the following: -Hire date of 9/9/25; -First date of contact with residents 9/9/25; -No documentation of an EDL or request for the EDL. 3. Review of the Maintenance Director's personnel file showed the following: -Hire date of 8/21/25; -First date of contact with residents was 9/9/25; -No documentation of an EDL or request for the EDL. 4. Review of LIMAA's personnel file showed the following: -Hire date of 7/26/25 -First date of contact with residents was 9/17/25; -EDL request dated of 9/24/25, after the employee's first date of contact with residents. 5. Review of LIMA B's personnel file showed the following: -Hire date of 9/24/25; -First date of contact with residents was 9/15/25; -Request for EDL was made on 9/24/25 and received on 10/9/25 after the employee's first date of contact with residents. 6. Review of LIMA F's personnel file showed the following:	A4714		

Missouri Department of Health and Senior Services

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A4714	Continued From page 8 -Hire date of 9/3/25; -First date of contact with residents 8/27/25; -No documentation of an EDL or request for the EDL. 7. Review of the Receptionist's personnel file showed the following: -Hire date of 8/20/25; -First date of contact with residents 8/13/25; -No documentation of an EDL or request for the EDL. During an interview on 10/9/25, the Administrator said; -The EDL should be completed before the employee has contact with the residents; -He thought the administrator at a sister facility completed the EDL on himself and the DON, he did not know why they were not done; -The Administrator should complete the EDL or verify that the EDL was done prior to the employee beginning work. *The higher classification merited due to the extent of the violation. MO258458	A4714		
A4750	19 CSR 30-86.047(28)(F)(1)(B) Community Based Assessment - Semi-Annually The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (F) Completes a community based assessment conducted by an appropriately trained and qualified individual as defined in section (4) of this	A4750		

Missouri Department of Health and Senior Services

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A4750	Continued From page 9 rule: 1. Time frame requirements for assessment shall be: B. At least semiannually; II This regulation is not met as evidenced by: Based on interview and record review, the facility failed to complete a Community Based Assessment (CBA-basic information and analysis describing a resident's abilities and needs) within in five calendar days of admission for one resident (Resident #2) of 11 sampled residents. The facility census was 12. The facility did not provide a policy for CBAs and the time frames in which they are done upon request. 1. Review of Resident #2's face sheet showed the resident admitted to the facility on 4/1/25 with diagnoses of Alzheimer's disease and hypertension. Review of the resident's medical record on 10/9/25 showed the following: -A pre-move in CBA completed on 3/31/25; -No CBA completed within five calendar days of admission. During an interview on 10/9/25 at 11:30 A.M., the Director of Nursing said she started working at the facility on 9/9/25, since then she has not had the time to complete any CBAs or had a chance to see what residents needed a CBA. During an interview on 10/9/25 at 7:30 P.M., the Administrator said he would expect a CBA to be completed in the required time frames.	A4750		

Missouri Department of Health and Senior Services

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{A4754}	Continued From page 10	{A4754}		
{A4754}	19 CSR 30-86.047(28)(G) Individual Service Plan - Develop The facility may admit or retain an individual for residency in an assisted living facility only if the individual does not require hospitalization or skilled nursing placement as defined in this rule, and only if the facility: (G) Develops an individualized service plan (ISP), which means the planning document prepared by an assisted living facility which outlines a resident 's needs and preferences, services to be provided, and goals expected by the resident or the resident 's legal representative in partnership with the facility; II This regulation is not met as evidenced by: This deficiency is uncorrected. For previous examples, see the Statement of Deficiencies dated 8/28/25. Based on interview and record review, the facility failed to develop an individualized service plan (ISP, the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and the goals expected by the resident or the resident's legal representative in partnership with the facility) for six residents (Residents #2, #6, #8, #9, #10, and #11) of 12 sampled residents. The facility census was 12. The facility did not provide a policy for the development of an ISP upon request. 1. Review of Resident #2's face sheet showed admission to the facility on 4/1/25 with diagnoses of Alzheimer's disease and hypertension. Review of the resident's electronic medical record	{A4754}		

Missouri Department of Health and Senior Services

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SAINT PETERS, MO 63376**

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{A4754}	Continued From page 11 on 10/9/25 showed no ISP in the medical record. During an interview on 10/9/25 at 11:30 A.M., Level One Medication Aide (LIMA) H and LIMA J said the following: -The ISPs are kept in a binder located at the nurses station on the assisted living side of the facility; -They do not have access to a resident's electronic medical record where the ISPs are maintained; -They only have access to the portion of the electronic medical record used to document administration of residents' medication. Observation of an unlabeled binder at the nurses station identified by LIMA H and LIMA J as the binder with resident ISPs, showed no ISP for Resident #2. 2. Review of Resident #6's face sheet showed the following: -Admitted to the facility on 8/27/25; -Diagnosis of Parkinson's disease (a chronic, progressive neurological disorder that affects movement), osteoarthritis, major depression, and coronary artery disease (a condition where the arteries that supply blood to the heart become narrowed or blocked). Review of the resident's electronic medical record on 10/9/25 showed no ISP in the record. Observation of the unlabeled binder at the nurses station identified by LIMA H and LIMA J as the ISP binder showed no ISP for Resident #6. 3. Review of Resident #8's face sheet showed the resident admitted to the facility on 9/1/25 with diagnosis of hypertension, heart failure,	{A4754}		

Missouri Department of Health and Senior Services

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{A4754}	Continued From page 12 osteoarthritis and osteoporosis. Review of the resident's electronic medical record on 10/9/25 showed no ISP in the record. Observation of the unlabeled binder at the nurses station identified by LIMA H and LIMA J as the ISP binder showed no ISP for Resident #8. 4. Review of Resident #9's face sheet showed admission to the facility on 9/1/25 with diagnosis of hypertension, osteoarthritis and kidney disease. Review of the resident's electronic medical record on 10/9/25 showed no ISP in the record. Observation of the unlabeled binder at the nurses station identified by LIMA H and LIMA J as the ISP binder showed no ISP for Resident #9. 5. Review of Resident #10's face sheet showed admission to the facility on 9/17/25 with diagnoses of diabetes, Alzheimer's disease, and hypertension. Review of the resident's electronic medical record on 10/9/25 showed no ISP in the record. Observation of the unlabeled binder at the nurses station identified by LIMA H and LIMA J as the ISP binder showed no ISP for Resident #10. 6. Review of Resident #11's face sheet showed admission to the facility on 9/6/25 with diagnoses of depression and hypertension. Review of the resident's electronic medical record on 10/9/25 showed no ISP in the record.	{A4754}			

Missouri Department of Health and Senior Services

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{A4754}	Continued From page 13 Observation of the unlabeled binder at the nurses station identified by LIMA H and LIMA J as the ISP binder showed no ISP for Resident #11. During an interview on 10/9/25 at 11:30 A.M., the Director of Nursing said she began working at the facility on 9/9/25 and had not had time to complete any ISPs since she began employment. During an interview on 10/9/25 at 7:30 P.M., the Administrator said the following: -ISPs should be completed upon admission and updated as conditions change; -The ISP should be kept in the resident's electronic medical record. He was working on getting the LIMAs access to the electronic medical record, until then, the ISPs should be kept in the binder for staff.	{A4754}			
A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class I* Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident #7) of 11 sampled residents. Resident #7 resided on the facility's locked Memory Care Unit and had a history of falls. Staff left the locked Memory Care Unit	A4776			

Missouri Department of Health and Senior Services

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HAMPTON MANOR OF ST PETERS

**268 JUNGERMANN ROAD
SAINT PETERS, MO 63376**

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A4776	Continued From page 14 unattended. During their absence from the unit the resident sustained a fall and suffered a fractured hip requiring hospitalization. Upon finding the resident on the floor, the resident could not move his/her right leg and was in severe pain. Staff did not call emergency services, but called the resident's hospice provider to assess the resident. The hospice provider did not come to the facility for over an hour after the staff called them. The hospice provider assessed the resident, noted the resident's right leg was externally rotated, shorter than the left leg, and was in severe pain. The hospice provider called emergency services and the resident was admitted to the hospital with a fractured hip requiring surgery. The facility census was 12. After multiple requests, the facility provided no policy regarding staff response to residents following a change of condition or emergent event or the facility policy regarding coordination of hospice care in such events. 1. Review of Resident #7's face sheet showed the following: -Admitted to the facility on 12/20/24; -Diagnoses of dementia. Review of the resident's Community Based Assessment (CBA, a comprehensive evaluation conducted to determine a resident's current health and support needs before admission and on an ongoing basis) dated 12/23/24, showed the following -Independent with ambulation and transfers. Fall risk was not marked; -Oriented, alert, cooperative, good behavior control; -Wanders inside the community, but does not	A4776		

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A4776	Continued From page 15 leave the building, confused, able to be easily redirected, potential for unintended exit from building. Review of the resident's Individual Service Plan (ISP, an individualized plan detailing a resident's specific needs, preferences, and the services they will receive. Developed after an initial assessment, the ISP outlines daily living activities, health and emotional support, social goals, and other care requirements to help the resident maintain their health and safety) dated 12/23/24, showed the following: -Transfer and mobility: does not need assistance with transferring or mobility; -Toileting: does not need assistance with toileting; -Not at risk for falls. Review of the resident's Comprehensive Care Plan Report from a local hospice dated 3/18/25 showed the following: -The resident is at moderate risk for falls; -Facility staff will demonstrate interventions to minimize fall risk and maximize safety and the resident will remain injury free from falls. Review of the resident's CBA dated 5/23/25 showed the resident was independent with transfers. Fall risk was not marked. Review of the resident's progress notes dated 9/22/25 at 2:54 A.M., signed by Level One Medication Aide (LIMA) K showed the resident was sent to the hospital per hospice. Review of the resident's progress notes dated 9/22/25 at 2:57 A.M., signed by LIMA K showed the following: -Heard the resident calling for help and found the resident on the floor by the bed. The resident	A4776		

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A4776	Continued From page 16 said he/she was going to the bathroom and fell. Vital signs were taken, Director of Nursing (DON) and the responsible party were notified. Called the resident's hospice nurse and and he/she reported he/she was on the way to see the resident. Nurse sent the resident to the hospital. Review of the resident's progress note dated 9/22/25 at 5:02 A.M., signed by the hospice nurse showed the following: -Resident was to have a bolster mattress, bed was supposed to be in the lowest position when not providing care; -Pain: unable to rate, the resident had facial grimacing, fists were clenched and unable to console, distract or reassure with severe pain to the right hip, unable to perform range of motion to the right hip, no bleeding or bruising noted; -Resident has a prior history of falls within the last three months and was at risk for falls; -There is shortening and external rotation of the right hip with severe pain, suspected fracture, sent resident to the local hospital; -The resident was in his/her room crying out, on the floor, laying on the right side beside the bed; -The resident had a fall from the bed this morning about 1:08 A.M., found laying on the right side complaining of severe pain, hip pain, unable to move the right leg. Hydrocodone (a potent, semi-synthetic opioid prescribed for the treatment of moderate to severe pain) was given. The resident was awake and responding appropriately, denies hitting head. The hydrocodone has been ineffective. The bed was at standard height. Educated the staff on fall precautions as the bed was not in the lowest position. Need re-enforcement for close monitoring due to frequent falls. Transferred to a local hospital via emergency personnel.	A4776		

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A4776	Continued From page 17 During an interview on 10/10/25 at 8:26 A.M., LIMA K said the following; -He/She was the only staff member scheduled for the Memory Care Unit on 9/22/25 for the 11:00 P.M. to 7:00 A.M. shift, there were two residents on the unit. There were two other staff members on the assisted living side; -The DON was in facility around midnight and wanted to have a meeting with all of the staff and called him/her to the assisted living side for this meeting; -Resident #7 was in bed when he/she left the unit to attend the meeting; -He/She was gone for the meeting about 15 or 20 minutes and when he/she returned he/she could hear the resident yelling "Help!, Help!". When he/she got to the resident's room, the resident was on the floor a few feet away from the bed with a comforter wrapped around his/her legs and he/she had been incontinent; This was the first time he/she had worked with the resident; -He/She tried calling the other two staff members on his/her cell phone, but there was no answer, so he/she left the resident to go get help, find a blood pressure cuff and a thermometer, and get the resident's personal information to call the responsible party and hospice. He/She was only away from the resident for a few minutes. The resident's information was on the assisted living side; -He/She found LIMA L who came to the Memory Care Unit to help him/her change the resident and take the vital signs; -The resident had severe pain in the right hip and could not be rolled over to the right to change him/her. The resident could not move his/her right leg; -He/She attempted to call the responsible party, but there was no answer. He/She called the DON who instructed him/her to call the hospice	A4776		

Missouri Department of Health and Senior Services

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A4776	Continued From page 18 nurse; -He/She called the hospice nurse, who said he/she would be at the facility to assess the resident; -He/She did not leave the resident, and stayed on the floor with the resident until the hospice nurse arrived about an hour after he/she had called him/her; -When the hospice nurse arrived and assessed the resident, he/she said it appeared the resident had fractured his/her hip and called an ambulance. The resident transferred to the hospital; -He/She was not aware of any facility policy regarding expectations when a resident falls and was in pain; -He/She knew when a resident had a fall and was in pain to not move the resident; -He/She did not know why it took so long for the hospice nurse to come to the facility. During an interview on 10/10/25 at 9:00 A.M., the DON said the following: -She had been in the facility on 9/22/25 on the midnight shift and had LIMA K leave the memory care unit for a short time; -She left after the meeting and received a phone call from LIMA K reporting the resident was found on the floor; -The resident was under hospice care, so she told the LIMA to call hospice. During an interview on 10/15/25 at 11:50 A.M., LIMA L said the following: -He/She worked on the Assisted Living side of the facility on 9/22/25 when Resident #7 fell; -The DON had been in the facility around midnight and called a meeting for all staff. LIMA K came from the Memory Care Unit to attend the meeting, he/she was the only staff member for	A4776		

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A4776	Continued From page 19 the Memory Care Unit; -When LIMA K went back to the Memory Care Unit, he/she found the resident on the floor; -LIMA L was in the laundry room and did not hear his/her phone ring. When he/she left the laundry room, LIMA K was on the assisted living side looking for help; -He/She went with LIMA K back to the resident's room to assist. The resident had been incontinent; -The resident was in a lot of pain and could not lay in his/her right side; -After he/she helped clean the resident up, he/she left the Memory Care Unit; -LIMA K was with the resident and the DON had told him/her to call hospice; -It was a long time before the hospice nurse came to assess the resident; -It wasn't very long after the hospice nurse was in the facility until the ambulance came and took the resident to the hospital. During an interview on 10/24/25 at 11:50 A.M., Hospice Nurse A said the following: -He/She received a phone call from the call center around 1:27 A.M. on 9/22/25 that the facility reported Resident #7 was found on the floor and had right leg pain. There was no other information given by the facility; -The facility had experienced frequent changes in DON and communication was not always good with the facility. Frequently when he/she did call the facility, there was never any answer. There had been a time when the facility was sending every resident on hospice to the hospital so they asked that they be notified and a hospice nurse would assess first then give instructions on whether to send the resident to the hospital. He/she was not sure what the current DON's policy was;	A4776			

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A4776	Continued From page 20 -He/She arrived at the facility at 2:15 A.M. and found the resident on the floor in an extreme amount of pain. LIMA K was with the resident and informed him/her he/she had given the resident hydrocodone at 1:45 A.M. and had called the DON at 1:10 A.M. and was given instructions to call hospice; -He/She assessed the resident and found the resident's right leg externally rotated and shorter and was in pain so he/she called emergency services. The ambulance arrived at the facility at 2:35 A.M. and the resident transported to a local hospital at 2:40 A.M. and admitted with a fractured hip; -If hospice had been told the resident was in extreme pain, and not able to move extremities, they would have instructed staff to call emergency services for transport. It takes a hospice nurse about an hour to get to the facility. During an interview on 10/14/25 at 2:30 P.M., the Hospice Director said the following: -Per the nurses notes, he/she had received the call from the facility at 1:03 A.M. on 9/22/25 and the hospice nurse lived about hour away from the facility; -He/She did not know what was reported to the hospice nurse, but if the resident could not get off the floor by themselves or with minimal assistance, then it was hospice policy to have the facility call for a lift assist from their local ambulance provider. During an interview on 10/15/25 at 11:30 A.M., the Administrator and Executive Director said the following: -They were not aware the resident had laid on the floor for such a long period of time; -The resident should not have laid on the floor in pain, staff should have called emergency	A4776		

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A4776	Continued From page 21 personnel; -The staff member should not have left the unit unattended for any reason. MO258509 *The higher classification merited due to the effect on the resident. NOTE: At the time of the visit, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level.	A4776			
A4817	19 CSR 30-86.047(51)(A)(1) Schedule II Meds-Reconcile Each Shift, Record Records shall be maintained upon receipt and disposition of all controlled substances and shall be maintained separately from other records, for two (2) years. (A) Inventories of controlled substances shall be reconciled as follows: 1. Controlled Substance Schedule II medications shall be reconciled each shift; II This regulation is not met as evidenced by:	A4817			

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A4817	Continued From page 22 Based on interview and record review, the facility failed to ensure inventories of Schedule II controlled substances (medications which have a high potential for abuse) were reconciled each shift. The facility census was 12. The facility did not provide a policy for inventories of Schedule II narcotics upon request. 1. Review of the facility's Controlled Substance Daily count sheets showed the following: -9/27/25 no off-going signature for or the shift noted on the form; -9/28/25 - 11-7 shift no on-coming shift signature; -9/29/25 - 7-3 shift no out-going shift signature; -9/29/25 - 11-7 shift no out-going shift signature; -9/30/25 - 7-3 shift no out-going shift signature; -10/2/25 - 11-7 shift no on-coming shift signature; -10/3/25 - 11-7 shift no out-going signature; -10/4/25 - 7-3 shift no out-going shift signature; -10/7/25 - 7-3 shift no on-coming shift signature; -10/7/25 - 3-11 no out-going shift signature; -10/9/25 - 3-11 shift no out-going shift signature. Review of the narcotics in the medication cart showed the following: -A card of Tramadol (an opioid pain medication used to treat moderate to moderately severe pain) 5 milligram tablets; -A card of Ativan (a medication used to treat anxiety) 0.5 mg; -Two cards of Xanax (medication used to treat anxiety) 0.5 mg. Observation on 10/9/25 at 3:15 P.M., showed Level One Medication Aide (LIMA) H and LIMA I count the narcotics in the medication cart. LIMA J signed the narcotic count book as the on-coming shift and LIMA I walked away from the medication cart without signing the book.	A4817			

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A4817	Continued From page 23 During an interview on 10/9/25 at 3:15 P.M., LIMA I said the following: -Each LIMA or nurse should sign the Controlled Substance Daily Count sheet when they come on the shift and as the out-going shift; -He/She did not know why LIMA H walked away without signing. 2. Observation on 10/9/25 at 4:30 P.M. of the Controlled Substance Daily Count book for the locked Memory Care Unit showed the following: -9/20/25 - 7-3 shift no out-going shift signature; -9/20/25 - 11-7 shift no out-going shift signature; -9/22/25 no 7-3 or 3-11 shift on-coming or out-going shift signature; -9/22/25 11-7 shift - no out-going shift signature; -9/23/25 - 7-3 shift no on-coming shift signature; -9/24/25 -7-3 shift, 3-11 shift or 11-7 shift no on-coming or out-going shift signatures; -9/25/25 - 3-11 no on-coming shift signatures; -9/26/25 - 7-3 shift - no on-coming shift signatures; -9/26/25 - 3-11 shift - no out-going shift signatures; -9/27/25- 7-3 shift no on-coming shift signature; -9/27/25 3-11 shift - no out-going shift signature; -9/28/25 and 9/29/25 -7-3 shift, 3-11 shift or 11-7 shift no on-coming or out-going shift signatures; -9/30/25 7-3 shift and 3-1 shift no on-coming or out-going shift signatures; -10/1/25 - 7-3 shift no on-coming shift signature; -10/1/25 - 3-11 shift - no out-going shift signature; -10/1/25 - 11-7 shift no on-coming shift signature; -10/2/25 - 7-3 shift on-coming or out-going shift signatures; -10/2/25 - 3-11 shift no out-going shift signature; -10/4/25 3-11 shift - no on-coming shift signature; -10/4/25 - 11-7 shift no out-going shift signature; -10/7/25 - 7-3 shift no on-coming shift signature.	A4817		

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A4817	Continued From page 24 Observation on 10/9/25 at 4:30 P.M. of the medication cart showed the following: -A card of hydrocodone/acetaminophen (narcotic pain reliever) 5-325 mg; -A box labeled lorazepam intensol 0.5 mg/ml. During an interview on 10/9/25 at 4:30 P.M., LIMA E said the following: -He/She did not have keys to the box labeled lorazepam and could not open the box to count the amount of liquid that was in the container; -He/She should have the key to open the box to count the medication; -Narcotic medication should be counted when coming on shift and when leaving the shift. During an interview on 10/15/25 at 11:30 A.M., the Administrator said all narcotics should be counted at the beginning and end of the shift and the count sheet should be signed. MO258458	A4817		

Plan of Correction - Hampton Manor of St. Peters

Survey Date: October 29, 2025

Facility: Hampton Manor of St. Peters

Address: 268 Jungermann Road, Saint Peters, MO 63376

Tag A4512 – Individualized Evacuation Plans

Deficiency	Failed to ensure residents needing more than minimal assistance had individualized evacuation plans integrated into the ISP.
Corrective Action Taken	An IEP was developed and implemented for Resident #4.
Systemic Changes	The DON completed a facility-wide audit of all residents to ensure each individual requiring more than minimal assistance has a current IEP accessible to staff. All staff in-serviced on IEP requirements, how to locate them, and their specific responsibilities during emergencies. A new policy titled "Individualized Evacuation Plans" was developed and implemented.
Monitoring/QA Plan	Monthly audits by DON for 3 months, or upon any change of condition, to ensure IEP completion and accuracy. Quarterly audits afterwards.
Responsible Party	DON
Completion Date	11/14/2025

Tag A4711 – Criminal Background Check

Deficiency	Facility failed to obtain background checks for 5 staff members.
Corrective Action Taken	Background checks were completed for all employees cited as well as scrub of all current employee files.
Systemic Changes	New hire processes and checklist were implemented to ensure FCSR background screenings are completed before any new employee is hired and allowed resident contact.
Monitoring/QA Plan	BOM to audit file prior to hiring and Administrator to conduct monthly audits, for 3 months, of all new hires to ensure compliance.
Responsible Party	Administrator
Completion Date	11/14/2025

Tag A4714 – EDL Inquiry

Deficiency	Facility failed to verify EDL status before allowing staff to work.
Corrective Action Taken	EDL checks were completed for all employees cited as well as scrub of all current employee files.
Systemic Changes	New hire processes and checklist were implemented to ensure EDL checks are completed before any new employee is hired.
Monitoring/QA Plan	BOM to audit file prior to hiring and Administrator to conduct monthly audits, for 3 months, of all new hires to ensure compliance.
Responsible Party	Administrator
Completion Date	11/14/2025

Tag A4750 – Community Based Assessment

Deficiency	Failed to complete CBA for Resident #2.
Corrective Action Taken	CBA completed for Resident #2.
Systemic Changes	“Community Based Assessment” policy created requiring CBAs within 5 days of admission, at least semi-annually, and whenever a significant change has occurred in the resident’s condition by appropriately trained and qualified personnel.
Monitoring/QA Plan	Audits of all potential move-ins prior to admission by DON and monthly audits, for 3 months, of all new move-ins conducted by Administrator.
Responsible Party	Administrator
Completion Date	11/19/2025

Tag A4754 – Individual Service Plan

Deficiency	Failed to develop ISP’s for residents #2, #6, #8, #9, #10, and #11.
Corrective Action Taken	ISP’s updated immediately for all six residents. Audit of all residents’ records was conducted to verify ISP’s are current and complete.
Systemic Changes	“Individual Service Plan Development” policy was created and implemented.
Monitoring/QA Plan	Monthly audits to ensure ISP’s are completed within 7 days of admission and

	reviewed quarterly.
Responsible Party	DON
Completion Date	11/19/2025

Tag A4776 – Protective Oversight

Deficiency	Failed to provide adequate protective oversight for resident #7 on the Memory Care Unit.
Corrective Action Taken	Resident #7 discharged on 9/21/25. There are currently no residents in Memory Care.
Systemic Changes	All staff in-serviced on "Fall Prevention and Management" policy, updated to include specifics on proper response and notification, specifically not to wait to notify EMS if someone is on hospice. All staff in-serviced on "Change of Condition" policy, updated to specify when to call 911 and who to notify. All staff in-serviced on "Care of Memory Care Residents" policy with emphasis on not leaving the Memory Care Unit unattended for any reason.
Monitoring/QA Plan	Staffing levels to be monitored by DON and audited monthly for 3 months. Falls meeting to be held weekly to discuss prevention and ensure proper processes were followed.
Responsible Party	DON
Completion Date	11/21/2025

Tag A4817 – Schedule II Meds-Reconcile Each Shift

Deficiency	Facility failed to reconcile controlled substances each shift.
Corrective Action Taken	Medication Aides and nurses were re-trained on completing shift counts and signing reconciliation logs.
Systemic Changes	Policy "Controlled Substance Handling and Reconciliation" was updated and implemented.
Monitoring/QA Plan	Random med audits weekly for 90 days, then monthly thereafter.
Responsible Party	DON
Completion Date	11/21/2025