STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265589	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Rehab and Healthcare Center	230 Spencer Road Saint Peters, MO 63376

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1) in a review of 11 sampled residents, remained free from physical abuse when on Certified Nurse Aide (CNA) B aggressively moved the resident in bed, causing the resident to yell out for help, and report CNA B was too rough and hurt him/her. The resident was tearful, upset and said he/she did not want CNA B to come back after the incident. The resident sustained bruising to the right arm as identified on the facility skin assessment dated [DATE]. During an interview on 9/4/25, the resident said he/she was scared of CNA B. The facility census was 78.On 9/10/25 at 2:54 P.M. the administrator was notified of the past noncompliance which occurred on 8/25/25. On 8/25/25 CNA B physically abused Resident #1 while providing his/her care in an aggressive manner. Licensed Practical Nurse (LPN) A stopped the care and asked CNA B to leave the facility. CNA B was terminated. The administrator and regional nurse provided education to staff members on abuse and neglect. The deficiency was corrected on 8/26/25. Review of the facility's Abuse Prevention and Prohibition Program policy, updated 10/24/22, showed the following:-Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property;-The facility conducts an ongoing review and analysis of abuse incidents and implements corrective actions to prevent future occurrences of abuse;-Resident assessments and care planning are performed to monitor resident needs and address behaviors that may lead to conflict; -The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect including:-Physical Abuse;a. Welts or bruises;-Possible signs and symptoms of psychological abuse or neglect;b. Paranoia;c. Inconsistent explanations for injuries;d. Anger. 1. Review of Resident #1's undated, face sheet showed the following:-The resident readmitted to the facility on [DATE];-He/She was his/her own responsible party;-Diagnoses included flaccid hemiplegia affecting left nondominant side (type of one-sided paralysis where the left side of the body is completely limp and lacks muscle tone, usually due to a brain or spinal cord injury), thrombocytopenia (blood has a lower-than-normal number of platelets), contracture (permanent shortening or tightening of muscles, tendons, or other soft tissues that limits the range of motion at a joint) of the left lower extremity, generalized anxiety disorder (chronic mental health condition characterized by excessive, persistent, and unreasonable worry or anxiety about various aspects of life), and Alzheimer's disease (progressive brain disorder that causes memory loss, confusion, and other cognitive decline). Review of the resident's care plan, dated 5/22/24, showed the following:-He/She had an activity of daily living (ADL) self-care performance deficit related to hemiplegia and generalized weakness;-He/She required maximal assist of one staff to turn and reposition in bed;-He/She was dependent on two staff for toileting;-The resident had impaired cognitive function due to diagnosis of Alzheimer's disease;-Cue, reorient and supervise as needed;-He/She had bowel incontinence;-Provide peri care after each incontinent (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	episode;-The resident had an alteration in hematological status related to thrombosis (clot);-He/She may bruise easily. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/14/25, showed the following:-The resident had moderately impaired cognition;-He/She had functional limitations in range of motion with bilateral upper and lower extremities;-He/She was dependent on staff on toileting hygiene;-He/She required maximal assistance of staff with bed mobility;-He/She was always incontinent of bladder and bowel. Review of the resident's weekly skin observation, dated 8/21/25, showed the resident had bruising to the back of his/her left hand. There were no other areas of concern or bruising identified. Review of the resident's weekly skin observation, dated 8/26/25, showed the resident had a bruise to his/her right arm. Review of a statement sent by Licensed Practical Nurse (LPN) A to the administrator on 8/25/25 at 7:24 A.M., showed the following:-He/She observed that the resident's eyes were teary, and the resident yelled, help me and make him/her stop hurting me. CNA B came in and woke me up out of my sleep, scared me half to death, and was being rough with me;-LPN A tried to provide the resident comfort, then observed CNA B attempting to leave the resident soiled, with his/her incontinence brief completely off, while covering him/her with only a sheet;-When he/she said he/she was going to assist, put on gloves and approached the resident, CNA B suddenly grabbed the resident and forcefully turned him/her to his/her side, nearly causing the resident to fall out of bed. CNA B then began aggressively pulling linens and soiled pads from underneath the resident, which caused feces to spread throughout the room;-Recognizing how aggressive the aide was acting, he/she told CNA B to stop before he/she caused the resident to fall. At that moment, two aides entered the room after hearing the resident scream;-He/She instructed them to continue assisting the resident while he/she removed CNA B from the room. During an interview on 9/4/25 at 9:44 A.M., LPN A said the following:-CNA B wanted him/her to document the resident refused care;-He/She went into the resident's room to ask what was wrong;-The resident was half undressed and covered by a single sheet;-The resident was tearful and said, CNA B woke him/her up and it scared him/her;-While LPN A put on gloves, CNA B went over to the resident's bed and started to handle the resident aggressively, rolling/moving the resident around in bed without telling the resident what CNA B was doing and was using force;-CNA B pulled on the resident to roll him/her over and put the resident too close to the side of the bed, so LPN A told CNA B to stop and let him/her help;-CNA B continued and the resident yelled for CNA B to stop because he/she was hurting the resident, so LPN A told CNA B to leave the room;-Two CNAs came in the room and LPN A told them to take over;-LPN A and CNA B left the room;-CNA B overheard LPN A talking on the phone about sending him/her home and CNA B started to threaten LPN A;-LPN A said CNA B was rough and careless with the care he/she witnessed. During an interview on 9/4/25 at 9:31 A.M., CNA C said the following:-He/She was on break with another staff member when he/she heard Resident #1 yell, stop hurting me! and you're too rough!;-When CNA C entered the resident's room, the resident yelled, help me! to him/her;-LPN A was in the resident's room and CNA B stood on one side of the resident's bed with one hand on the resident's arm and the other hand on the resident's leg, bending the resident at the waist while trying to move the resident;-The resident had contractions and was limited on how far he/she could bend;-The resident said CNA B hurt him/her;-LPN A told CNA B to leave the room and CNA C and CMT D took over;-The resident was upset and tearful and said he/she did not want CNA B to come back;-CNA B was being unnecessarily rough and hurt the resident.-CNA told the administrator the resident yelled for help, said CNA B hurt him/her and the resident was upset. During interview on 9/4/25 at 9:52 A.M., the resident said the following:-CNA B was rough and hurt him/her;-He/She was scared of CNA B and didn't want CNA B to go near him/her. Review of the resident's next of kin's text (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	message sent to the surveyor, dated 8/30/25 at 11:57 A.M., showed on 8/29/25, the next of kin spoke with the resident in the hospital, where the resident was being treated for pneumonia. The resident had bruising; the resident said the staff member was rough. Observation of a photo sent from the resident's next of kin to the surveyor of the resident's right arm, dated 8/30/25 at 11:57 A.M., showed the following:-The resident had purple discoloration of the skin of the upper arm approximately 10 centimeters (cm) in width, unable to determine the length because the edges were not visible;-There was a second area of purple discoloration of the skin on the right upper arm below the bend of the elbow that was approximately 6 cm in width, unable to determine the length because the edges were not visible;-There was a third area of purple discoloration of the skin on the lower right arm that was approximately 4 cm x 4 cm;-There was a fourth area of purple discoloration of the skin on the lower right arm, below and to the right of the third area and it was approximately 1 cm x 1 cm. During an interview on 8/29/25 at 2:50 P.M., and on 9/10/25 at 12:30 P.M. the Administrator said the following:-She worked in the facility at the time of the alleged abuse;-The alleged abuse occurred at 3:00 A.M. and the charge nurse, Licensed Practical Nurse (LPN) A an agency nurse said, CNA B worked with Resident #1 when he/she heard the resident wanted him/her to stop;-CNA B had the resident rolled over on his/her side and the resident said he/she didn't want CNA B taking care of him/her anymore;-Two CNAs came in the room and took over caring for the resident;-LPN A and CNA B left the resident's room and LPN A told CNA B to go home;-LPN A provided a statement and the investigation was begun;-The resident said CNA B scared him/her when CNA B woke him/her up and he/she didn't realize who it was at first moving him/her around in bed;-She completed an assessment on the resident immediately after the incident;-The resident had two bruises on the right arm, the upper one on the forearm was quarter sized, and the lower one on the forearm was not quite quarter sized. 26036502605591