

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Heritage Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4401 North Hanley Road Saint Louis, MO 63134	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30687</p> <p>Based on observation, interview and record review, the facility failed to ensure one resident's right to be free from physical abuse was not violated when one resident (Resident #2) and another resident (Resident #3) were involved in three resident to resident altercations before Resident #2 was moved to another hall. In addition, the facility did not update the residents' care plans with interventions after each resident to resident altercation. The sample was five. The census was 112.</p> <p>Review of the facility's Abuse and Neglect Policy, dated 6/12/24, showed the following:</p> <p>-Purpose:</p> <p>-It is the policy of this facility ensure all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;</p> <p>-Physical Abuse:</p> <p>-Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior;</p> <p>-Protection of Residents:</p> <p>The Facility will take steps to prevent mistreatment while the investigation is underway;</p> <p>-Residents who allegedly mistreat another resident will be removed from contact with the resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement considering his or her safety, as well as the safety of other residents and employees in the facility.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 265534	If continuation sheet Page 1 of 5

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/24, showed the following:</p> <ul style="list-style-type: none"> -Moderate cognitive impairment; -No moods or behaviors; -Independent with activities of daily living (ADLs); -Diagnoses of high blood pressure, anxiety, depression and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). <p>Review of the resident's nurse's note, dated 4/29/24, showed the following:</p> <ul style="list-style-type: none"> -4:54 P.M., the resident was involved in an altercation with another resident. The resident's guardian was informed; -5:05 P.M., the resident was sent out to hospital for evaluation and treatment concerning altercation with another resident; -7:36 P.M., the resident's physician was contacted by the Director of Nursing (DON). A message left on non emergent line. The psychiatric nurse practitioner was contacted at 5:22 P.M. regarding altercation; -10:35 P.M., the resident arrived via ambulance back to facility. The resident calm and cooperative with staff and peers. The resident denied being in any pain. There were no new orders at the moment. The resident will continue to be monitored throughout the night. <p>Review of the resident's nurse's note, dated 8/17/24, showed the following:</p> <ul style="list-style-type: none"> -5:56 P.M., this writer visited the B hall unit to report new orders to charge nurse, while standing with the charge nurse at the nurse's medication cart in the middle of the hallway, this writer noted the resident walking up the B hallway towards the top of the hall. Moments later I heard a noise, my back was towards the sound so as I turned to investigate the noise, I noticed another resident yelling at the resident (Resident #2) on the floor. My view was blocked by the food cart. Upon assessment with full view I noted the resident was on the floor with a small amount of blood to the left side of his/her eye and nose. Code green (resident altercation) was initiated. The staff aided the resident and kept him/her safe from the other resident. The staff arrived promptly and professionally to diffuse this situation. The resident was agitated and aggressive with staff for a moment, however later, staff were able to redirect his/her behavior and clean and apply dressing to his/her injury; -5:57 P.M., a call was placed to the resident's physician's exchange to report and obtain orders for injuries. Currently waiting for a response. <p>Review of the resident's current care plan, showed no documentation of interventions regarding the two altercations on 4/29/24 and 8/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurse's note, dated 9/1/24 at 11:28 A.M., showed it was reported to this nurse on B hall that resident and another resident were involved in an altercation. Upon assessment the resident was unwilling to speak with this nurse about the incident. The resident was assessed with no known injuries. The resident reports no pain. It was explained to this nurse the resident was seen leaving the other resident's room with a soda belonging to the other resident, resulting in the other resident to hit the resident in his/her chest several times. The two naturally separated before staff were able to intervene.</p> <p>Review of the resident's care plan, dated 9/1/24, showed the following:</p> <ul style="list-style-type: none"> -Problem: Resident to Resident Altercation: Resident was hit by another resident as he/she exited the room; -Desired Outcome: Resident will remain safe during stay at facility; -Interventions: Room change/Continue to monitor for any behavioral changes <p>During observation and interview on 9/11/24 at 11:01 A.M., the resident said he/she was doing fine. The resident said he/she did not remember the altercation and felt safe. Observation at that time showed the resident resided on the C Hall.</p> <p>Review of Resident #3's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -No cognitive impairment; -Physical and verbal behaviors for one to three days; -Independent with ADLs; -Diagnoses of high pressure and schizophrenia. <p>Review of the resident's nurse's note, dated 4/29/24, showed the following:</p> <ul style="list-style-type: none"> -5:09 P.M., the resident was in an altercation with another resident concerning money that was owed to him/her. The residents had words back and forth, and then this resident proceeded to punch the other resident several times in the face. The fight was deescalated and resident then went into his/her room to calm down. The resident will be sent out to hospital to evaluation and treatment; -5:19 P.M., the resident is being sent out to hospital. The DON is calling report to hospital staff and requesting labwork; -10:22 P.M., the resident returned to facility via ambulance. The resident is cooperative with peers and staff. The resident was placed on one on one monitoring and observation. The resident denied any pain and will continue to monitor the resident throughout the night. <p>Review of the resident's care plan, showed no documentation of interventions regarding the 4/29/24 altercation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurse's notes, dated 8/17/24 at 6:03 P.M., showed this writer visited the B hall unit to report new orders to the charge nurse. While standing with the charge nurse at the nurse's medication cart in the middle of the hallway, I heard a noise but my back was towards the sound so as I turned to investigate the noise. I noticed the resident (Resident #3) standing over and yelling at another resident who was on the floor. My view was blocked by the food cart, upon assessment with full view I noted that the resident was in an altercation with another resident. A code green was initiated. The staff asked the resident what happened? The resident said that cohort came in his/her room and stole his/her things. This writer asked the resident to report what was missing. The resident said he/she didn't know. The staff asked the resident to go into his/her room and check to see what was missing. The resident entered his/her room and noticed that his/her roommate was in the room lying on the bed. The resident came out of the room and reported that nothing was missing. The staff removed the resident from the B hall unit and went to the DON's office to get his/her statement. The resident denied pain or discomfort.</p> <p>Review of the resident's nurse's note, dated 9/1/24 at 11:48 A.M., showed it was reported to this nurse that on B hall, the resident and another resident were involved in an altercation. The resident (Resident #3) explained that the other resident was stealing (his/her) stuff. The resident was assessed and had no known injuries. The resident reports no pain. The resident was showing signs of agitation, speaking loudly and using profanities. The resident was talked down. It was explained to this nurse the other resident was seen leaving the resident's room with a soda belonging to the resident, resulting in the resident hitting the other resident in his/her chest several times. The two naturally separated before staff were able to intervene.</p> <p>Review of the resident's care plan, showed a new intervention, dated 9/2/24, of a room change to another hall for the other resident.</p> <p>During an interview on 9/11/24 at 8:40 A.M., Resident #3 said he/she did have an altercation with Resident #2 because he/she goes into people's rooms and steals their things. The resident said he/she felt he/she was defending his/her things. The resident did not have anything against the other resident.</p> <p>During an interview on 9/12/24 at 10:01 A.M., Licensed Practical Nurse (LPN) A said he/she had only worked at the facility for a couple of months. LPN A said Resident #2 should not be on the B hall because it's a locked unit of more aggressive residents. The two residents have had two altercations to his/her knowledge. He/She was not aware of the altercation in April. LPN A said Resident #2 should have been moved after the second altercation. LPN A said the resident is adjusting well on the C hall.</p> <p>During an interview on 9/12/24 at 10:15 A.M., Hall Monitor (HM) B said on 9/1/24 he/she was doing smoke breaks, and he/she looked up the hall and saw Resident #3 beating up Resident #2 because he/she stole a soda. HM B intervened and called a code green. HM B said about a week or so prior (unknown date), the two had an altercation. HM B said they finally moved Resident #2 to the C Hall after the 9/1/24 altercation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24 at 11:46 A.M., the DON, Administrator and Regional Corporate Nurse (RCN) said they would expect the abuse/neglect policy to be followed. The DON said Resident #2 has had aggressive behaviors, and she did not think he/she would do well with dementia residents on the C hall. The DON said after the altercation on 9/1/24, Resident #2 was moved to the C hall and has been monitored and has not had any behaviors. The DON said maybe they should have moved Resident #2 sooner.</p> <p>MO00241428</p>		