

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Atrium Place Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Redman Road Saint Louis, MO 63136	

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** 35394</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when two residents were involved in physical resident to resident altercation, after an argument escalated with both residents hitting each other (Residents #1 and #2). The residents were separated by staff and other nearby residents. The sample was four. The census was 91.</p> <p>The facility was notified of past non-compliance on 9/25/24. Facility staff notified administration, separated the residents, and provided assessment and services to the involved residents. Staff were in-serviced on the abuse and neglect prevention, intervention and de-escalation of resident arguments and disagreements. This deficiency was corrected on 9/18/24.</p> <p>Review of the facility's Abuse, Neglect and Exploitation, showed:</p> <ul style="list-style-type: none"> -Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property; -The facility will have written procedures to assist staff in identifying the different types of abuse: mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations; -An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur; -The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: <ul style="list-style-type: none"> -Responding immediately to protect the alleged victim and integrity of the investigation; -Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; <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
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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>-Increased supervision of the alleged victim and residents;</p> <p>-Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator;</p> <p>-Protection from retaliation;</p> <p>-Providing emotional support and counseling to the resident during and after the investigation, as needed;</p> <p>-Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/16/24, showed:</p> <p>-Diagnoses included hypertension (high blood pressure), kidney failure, obstructive uropathy (urine is unable to drain through urinary tract), Parkinson's disease (chronic, progressive nervous system disorder), malnutrition, schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly) and asthma;</p> <p>-No cognitive impairment;</p> <p>-No behaviors.</p> <p>Review of the resident's care plan, in use during survey, showed:</p> <p>-Focus: Resident smokes tobacco. Resident has a history of begging for cigarettes;</p> <p>-Goal: Resident will adhere to the tobacco/smoking policies of the facility;</p> <p>-Intervention: Cigarettes (or other smoking materials) and lighter at nurse's station;</p> <p>-Conduct smoking safety evaluation on admission and as needed (PRN);</p> <p>-Educate resident/ responsible party on the facility's tobacco/ smoking policy;</p> <p>-If a smoking facility, orient resident to smoking times and procedures;</p> <p>-Notify charge nurse immediately if it is suspected resident has violated facility smoking policy;</p> <p>-Focus: The resident has a behavior problem related to struck a resident after resident had ran over his/her foot with his/her wheelchair;</p> <p>-Goal: Resident will have no evidence of behavior problems;</p> <p>-Interventions: Anticipate and meet the resident's needs;</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>-Nurse Practitioner (NP) assess if need for further medical attention, monitor for pain, and swelling;</p> <p>-Urinalysis (UA, a lab test that checks for bacteria in the urine) and culture and sensitivity (C&S) and routine labs.</p> <p>Review of Resident #2's quarterly MDS, dated [DATE], showed:</p> <p>-Diagnoses included hypertension, peripheral vascular disease (circulatory condition), hyperlipidemia (high level of lipids in the blood), depression,</p> <p>-Moderate cognitive impairment;</p> <p>-No behaviors.</p> <p>Review of Resident #2's care plan, in use during survey, showed:</p> <p>-Focus: The resident has a behavior problem. Resident has been noted smoking marijuana while in the facility;</p> <p>-Goal: The resident will have fewer episodes of behavior;</p> <p>-Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness;</p> <p>-Caregivers provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by;</p> <p>-If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident;</p> <p>-Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention, remove from situation and take to alternate location as needed;</p> <p>-Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes;</p> <p>-Praise any indication of the resident's progress/improvement in behavior;</p> <p>-Provide a program activities that is interest and accommodates residents status;</p> <p>-Focus: Resident is dependent on tobacco and requires staff supervision during smoke breaks;</p> <p>-Goal: The resident will have minimized risk of injury from unsafe smoking practices;</p> <p>-Interventions: Cigarettes (or other smoking materials) and lighter nurse's station;</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>-Educate resident about smoking risks and hazards. Encourage resident to participate in a smoking cessation program;</p> <p>-Instruct resident about the facility policy on smoking: Locations, smoke times, facility rules, and safe smoking practices;</p> <p>-Notify social worker/administrator immediately if it is suspected resident has violated facility smoking policy;</p> <p>-Observe clothing and skin for signs of cigarette burns;</p> <p>-The resident requires supervision while smoking;</p> <p>-Focus: The resident has a behavior issue related to resident to resident, striking at another resident after running over his/her foot;</p> <p>-Goal: The resident will have no evidence of behavior issues physical aggression;</p> <p>-Intervention: Remove from motorized wheelchair. Therapy to re-evaluate for safe use while in motorized wheelchair for safety;</p> <p>-Supervise safety after separation.</p> <p>Review of Resident #2's progress notes, showed:</p> <p>-On 9/18/24 at 2:07 P.M., during smoke break residents were lined up to go outside. Resident #1 tried to rush past the other residents that were waiting which caused him/her to have his/her foot ran over by this resident's motor chair. Both residents were separated by staff. NP & Director of Nursing (DON) notified. Residents are on one on one observation this shift;</p> <p>-On 9/19/24 at 7:11 A.M., patient remains on observation for resident to resident. Patient has been in his/her room throughout the night resting with eye closed breathing non labored. Patient voiced no complaints of pain and no signs and symptoms of distress. Patient vital signs 128/70 (blood pressure), 68 (pulse), 18 (respirations), 98% (oxygen saturation) room air. Patient in a pleasant mood. Patient up and in chair in dining room waiting to go smoke at this time. Plan of care ongoing;</p> <p>-On 9/20/24 at 6:57 A.M., patient remains on observation for resident to resident. Patient has been in his/her room throughout the night resting with eye closed breathing non labored. Patient voiced no complaints of pain and no signs and symptoms of distress. Patient in a pleasant mood. Patient up and in chair in hallway talking to other resident waiting to go smoke at this time. Plan of care ongoing;</p> <p>-On 9/20/24 at 2:41 P.M., resident remains on observation for resident to resident altercation. No behaviors noted. Resident currently in the dining room playing cards with other residents. Will continue to monitor;</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>-On 9/21/24 at 3:11 P.M., resident remains on follow-up observation day 2/3 due to resident to resident altercation. No behaviors were noted during the evening shift. Vitals signs are stable. Presently resting in bed with both eyes closed, breathing is non-labored;</p> <p>-On 9/22/24 at 1:11 A.M., resident remain on follow-up observation day 3/3 due to a resident/resident verbal altercation. No altercations noted or reported this evening, nor through the night. Presently resting in bed with both eyes closed. Respirations even and non-labored;</p> <p>-On 9/22/24 at 1:39 A.M., resident declined to have vital signs taken. Stated, someone else already checked them.</p> <p>Review of Resident #1's progress notes, showed:</p> <p>-On 9/18/24 at 10:27 A.M., resident reported to be in a resident-to-resident altercation. Resident seen standing near nurses station, agreeable to talk to this writer. Reports other resident ran over toe with wheelchair and he/she was pushed in chest. Agreeable to physical exam. Resident alert and appears in no distress. Slight smell of urine noted. Additionally, appears urine on floor in room. Bilateral feet dry with onychomycosis (fungal infection). Hypertrophic toenails (increase of soft tissue volume at the distal edge of the nail). No redness, cuts, bruises or pain when feet palpated. Labs ordered, UA with CS added. Discussed with resident, resident is agreeable at this time. Foot care provided, toenails trimmed and filed with Dremel (a tool used to remove excess skin and overgrown nails). Resident tolerated well;</p> <p>-On 9/18/24 at 2:23 P.M., resident had an altercation with another resident. At pervious smoke session this resident jumped the line of resident heading outside to smoke causing the other resident to hit his/her foot with his/her power chair. This resident then spilled some of his/her coffee. The resident began to have a verbal altercation thinking each resident did what they did on purpose. Both residents were separated and assessed. NP was present so he/she was informed of event. No new orders (NNO) or injuries received. Will continue to monitor both parties;</p> <p>-On 9/18/24 at 7:25 P.M., resident has UA sample in fridge. Resident tolerated procedure well. Will notify physician of results;</p> <p>-On 9/19/24 at 7:12 A.M., patient remains on observation for resident to resident. Patient has been in his/her room throughout the night resting with eyes closed breathing non labored. Patient voiced no complaints of pain and no signs and symptoms of distress. Patient vital signs 135/72 (blood pressure), 18 (respirations), 98.1 (temperature), 99% (oxygen saturation) room air. Patient up in a pleasant mood. Patient in dining room waiting for breakfast. Patient asked this nurse to warm up coffee, this nurse did as patient asked. Patient has no new concerns. Plan of care ongoing;</p> <p>-On 9/20/24 at 7:03 A.M., Patient remains on observation for resident to resident. Patient has been in his/her room throughout the night resting with eyes closed, breathing non labored. Patient voiced no complaints of pain and no signs and symptoms of distress. Patient vital signs 132/76 (blood pressure), 18 (respirations), 80 (heart rate), 97.8 (temperature), and 99% oxygen saturation room air. Patient up in a pleasant mood. Patient near nursing station watching morning news, waiting to go smoke. Patient has no new concerns, Plan of care ongoing.</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 9/23/24 at 10:05 A.M., Resident #1 said he/she went out of the door to go outside to smoke, and Resident #2 got in the way. He/She ran over his/her left toe. There was a little bit a pain at the time. Resident #1 said, you ran over my toe and Resident #2 said, you were in my way and then you need to watch yourself. Resident #1 replied, I do not have to do it and Resident #2 responded I will do it again. Resident #1 and Resident #2 started to call each other names. Resident #1 repeated what he/she said to Resident #2, you no good (man/woman), you were with all those (men/women). Resident #2 said, I'll do it again and beat your ass. Resident #2 hit Resident #1 in the upper chest and Resident #1 hit Resident #2 on the back on his/her neck. Resident #2 started swinging, but Resident #1 got out of the way. Resident #1 said he/she set his/her coffee down and they started to fight, but staff broke it up. Resident #2 said you cannot whoop my ass. Resident #1 said, bitch, [NAME], you prostitute punk, you were in my way. He/She said Resident #2 was not going to do anything. Resident #1 said he/she never been in a wheelchair, so Resident #2 is not doing nothing. Resident #2 thinks he/she was going to whoop my ass. He/She needs to go back to the other table with his/her friend. Resident #1 was not hurt. The foot stung, but that was it. There was no pain, redness, bruising, or swelling to the foot. He/She had staff cut down his/her toenail. The coffee spilled a little on him/her and did spill on Resident #2. There were no in the past issues with Resident #2. He/She never saw Resident #2 in an altercation. He/She feels safe at the facility.</p> <p>During an interview on 9/23/24 at 9:50 A.M., Resident #2 said it was during the smoke break. He/She was sitting at the door, and Resident #1 crossed him/her and went out the door. He/She started to spill the coffee and Resident #2 said do not spill your coffee on me. Resident #1 said something, but Resident #2 did not remember what he/she said, but Resident #1 hit him/her. Resident #1 only hit him/her on the shoulder, and it did not hurt. Resident #2 did not hit Resident #1 back because after he/she hit him/her, Resident #1 ran to the door and told staff that Resident #2 rolled over his/her foot. That was a lie. Resident #2 said he/she was 200 pounds and this is a big wheelchair and if I rolled over his/her foot, he/she would not be able to walk around at all. Resident #1 always picks on other residents, but Resident #2 never witnessed Resident #1 in a physical altercation. Resident #1 thinks he/she is Sergeant of Arms around here. Resident #2 said he/she felt safe.</p> <p>Review of the facility's abuse investigation report, showed:</p> <ul style="list-style-type: none"> -Date/time alleged incident reported: 9/18/24 at 10:18 A.M.; -Date/time alleged incident occurred: 9/18/24 at 9:20 A.M.; -Location of incident: smoke area; -Name of person who reported alleged incident: Housekeeper A -Type of abuse: physical; -Summary: Resident #2 states he/she was in the doorway waiting to go out to smoke. When the door opened, Resident #1 rushed past him/her, nearly spilling his/her coffee on Resident #2. Resident #2 states do not run in front of me before I run you over, and you almost spilled coffee on me. Resident #1 took that as a threat and began cursing at him/her and then they both went back and forth with threats of hitting. He/She states Resident #1 hit him/her and a resident jumped in to stop it before he/she could hit back; <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>-Summary of interviews with witnesses: Witnesses state they saw residents hitting each other for a brief period before being separated. No witness was able to clearly state if it was the running over Resident #1's toe or just Resident #2's verbiage that started the verbal aggression. Witnesses agree the situation was handled quickly and appropriately;</p> <p>-Summary of interviews with staff: Staff agrees there was verbal altercation that proceeded physical. It is unclear if he/she rolled over his/her toe or if it was Resident #2's comment that started the verbal. Staff agrees it was handled quickly and appropriately;</p> <p>-Summary of investigation findings: The facility has completed investigation including interviews with residents and staff. It can be concluded that there was an altercation between Resident #2 and Resident #1. Based on interviews and assessments, the facility cannot conclude that Resident #2 ran over Resident #1's foot. Both residents have continued their normal daily routines and have had no further issues or psychosocial decline. Both stated they feel safe in facility;</p> <p>-Outcome of the investigation and any interventions/changes to plan of care: As a result of this incident, police were notified as well as NP and regional supervisors. Residents were separated and closely monitored by staff. They were thoroughly assessed for pain, injury, mental well-being and safety and comfort. Staff and residents have been informed that there must be a single-file line when going out to smoke.</p> <p>Review of Resident #3's written statement, dated 9/18/24, showed:</p> <p>-Did you see a resident to resident altercation: yes;</p> <p>-Who hit who first: Resident #2 did not run over his/her feet. Resident #1 swung on him/her first. Resident #2 was not able to swing back because they jumped in the middle. He/She was trying to go outside and Resident #1 almost run into him/her. He/She said do not run in front of me because I am able to run you over. He/She did not mean it like that, but just letting him/her know to be careful because he/she could get run over;</p> <p>-Was staff present? How was it stopped: The girl smoking us tried to stop it, but Resident #1 over powered him/her and he/she yelled for help. Resident and kitchen guy stopped it;</p> <p>-Do you continue to feel safe: Yeah I feel safe.</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 9/23/24 at 9:10 A.M., Resident #3 said he/she witnessed the altercation between the two residents. He/She was outside next to Resident #2. Both residents were in the wrong on how the situation was handled. Resident #1 almost spilled his/her coffee and Resident #2 moved back in his/her wheelchair and said, you almost spilled coffee on me. Then Resident #2 went off. Resident #3 did not remember what was said, but Resident #1 started moving toward Resident #2. No coffee was spilled on the residents. When Resident #1 started moving toward Resident #2, he/she swung at him/her, and Resident #2 swung back. They both missed. Resident #3 said he/she got in between the two residents and tried to break it up. Staff was there as well. Staff was young and skinny. He/She tried to break it up, verbally and then physically by putting him/herself in between the residents. The wheelchair never rolled over Resident #1's feet. That was a motorized wheelchair and if he/she rolled over his/her foot, everyone would have known about it. That is a heavy wheelchair. You would not be able to do anything after that. Residents #1 and #2 had never been in a altercation prior to this. They do not interact with each other. They usually sit on opposite sides of the smoking area. Maybe they had a bad day, but to Resident #3's knowledge, it was a one time thing that he/she witnessed. They did not have altercations with other residents.</p> <p>Review of Resident #4's written statement, dated 9/18/24, showed:</p> <p>-Did you see a resident to resident altercation: Yeah I was right there;</p> <p>-Who hit who first: Both swung at the same time. I do not know what it was about;</p> <p>-Was staff present? How was it stopped: I tried to stop it. I rolled my chair between them. My whole point was to try to stop. I think Resident #1 almost spilled coffee on Resident #2;</p> <p>-Do you continue to feel safe: Yeah I feel very safe.</p> <p>Review of Housekeeper A's written statement, dated 9/18/24, showed:</p> <p>-When did you last see these residents: When we were outside smoking;</p> <p>-Did you observe an altercation: Yes, I got in between them to stop it;</p> <p>-Who hit who first: Resident #1;</p> <p>-How was it stopped: Me and a resident broke it up.</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 9/23/24 at 10:32 A.M., Housekeeper A said it all happened in a second. He/She was at the door to go to the outside patio. Resident #2 was in line. As soon as he/she handed Resident #2 the cigarette, Resident #1 tried to get by him/her. He/She heard Resident #1 say, you can't just rush, wait a minute. Housekeeper A said Resident #1 tried to go around them. Then Housekeeper A heard, I'll beat your ass. It was basically someone jumping in front of someone over a cigarette. Housekeeper A told Resident #1 to walk around to the other side, but came back to Resident #2. Resident #2 said Resident #1 thinks he/she is special. When they got their cigarettes, they were still arguing. Both residents hit each other at the same time. They went up to each other and started hitting each other. Resident #1 was hit in his/her upper chest. Resident #2 was hit, on his/her arm. It was open handed. Housekeeper A got in between them along with another resident. Housekeeper A had Resident #1 and the other resident was keeping Resident #2 away. As soon as he/she saw the residents swing, they were separated. It happened near the door, so other residents did not get to go out because they started fighting. The residents yelled for staff. Administrator and other staff arrived, but Housekeeper A broke up the altercation and stayed until staff arrived. No one was hit in the face. Coffee had spilled, but Housekeeper A was not sure if it spilled on a person. It could have spilled on Resident #1 because he/she was holding it. Resident #1 always has a cup in his/her hand and always spills coffee. Housekeeper A was not sure if the coffee was hot, but he/she always has his/her cup. Housekeeper A never witnessed Resident #2's wheelchair run over his/her foot. Resident #2 is good and he/she flies in the wheelchair, but he/she was not moving quick in his/her wheelchair at that time. He/She was already there. Resident #1 was in a hurry and tried to get in front of the line. Housekeeper A said he/she felt the other residents pick on Resident #1 sometimes. He/She told Resident #1 to ignore Resident #2, but Resident #1 ended up walking near Resident #2 and Resident #2 moved closer to Resident #1, and that was when it happened. It happened so fast. It was about five minutes from the time they received their cigarettes, argued, started fighting, and were separated. Housekeeper A never witnessed the residents in an altercation with each other or other residents before. Since the incident, they have been to make sure the residents are separated when they are smoking. There have been no arguments.</p> <p>During an interview on 9/23/24 at 12:57 P.M., Certified Nurse Aide (CNA) B said he/she was there on that day. He/She witnessed it, but he/she was in the dining room. It was early in the morning and he/she believed Housekeeping was also with the residents. He/She saw Resident #2 roll over Resident #1's foot. Resident #1 said something to Resident #2. He/She said, you rolled over my foot. Resident #2 said I should have rolled over you. They were all going out the door. Resident #2 was behind Resident #1 and hit his/her foot. When Resident #2 hit Resident #1's foot, CNA B did not remember if anyone intervened. Resident #2 rolled past him/her, and he/she was outside at that point. Both residents were back and forth with the names. Resident #2 hit Resident #1 first on his/her shoulder. Resident #1 hit Resident #2 back and that was the end of it. CNA B took Resident #1 and walked around the nurse's station and then he/she went to their room. CNA B did not see Resident #1 again that morning. Resident #1 said he/she was fine. The other residents think Resident #1 is a snitch because he/she snitches on their illegal activities. CNA B thought the wheelchair incident was an accident, but then Resident #2 said, I should have rolled over you. CNA B believed Resident #2 showed off in front of his/her friend. CNA B said neither resident had a history of aggressive behavior. The other residents believe Resident #1 is a snitch, so they do not interact with him/her like that.</p> <p>During an interview on 9/23/24 at 7:45 A.M., the DON said both residents are still in the facility, but they do not reside on the same hall. There have been no issues since the altercation. They stay out of each other's way. The residents never had any physical altercation or verbal alteration history.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Atrium Place Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Redman Road Saint Louis, MO 63136	
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>During an interview on 9/23/24 at 8:50 A.M., the Administrator said Resident #1 said Resident #2 rolled over his/her foot. Resident #2 said it did not happen. There were no injuries to the resident's foot. At 1:00 P.M., the Administrator said the other residents believe Resident #1 is a snitch. The younger residents try to smoke marijuana and he/she tells staff. He/She keeps to him/herself for the most part. If someone makes fun of him/her, that does set him/her off as well. The resident is often bored, so they find activities for him/her to do. He/She was not able to purchase cigarettes in the past, so staff purchased them for him/her. The resident offered to help out with activities, but the other residents thought he/she was special or received special treatment. Resident #2 stays under the radar because he/she often did things he/she should not do. He/She plays cards and visits with another resident he/she is in a relationship with. There had been no reports of altercations and or further concerns.</p> <p>During an interview on 9/25/24 at 2:20 P.M., the Administrator said the in-service, dated 9/18/24, included intervening when residents are in an argument. Housekeeper A thought the argument was over; however, Resident #1 walked back around to Resident #2 and they started again. The Administrator expected staff to intervene and de-escalate arguments between residents, so it will not become a physical altercation.</p> <p>MO00242261</p>		