

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2025
NAME OF PROVIDER OR SUPPLIER  Sage Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  3421 Gasconade Saint Louis, MO 63118	

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 - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46970</p> <p>Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when residents were involved in physical resident to resident altercations. Staff witnessed Resident #6 engage in a verbal altercation with Resident #5. Resident #5 then choked the neck of Resident #6, which caused bruising to the resident's neck and a sore throat. The sample was 8. The census was 87.</p> <p>Review of the facility's Abuse Prevention and Prohibition Program, revised 10/24/22, showed:</p> <p>-Purpose: To ensure the facility establishes, operationalizes, and maintains an abuse prevention and prohibition program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements;</p> <p>-Policy: Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property;</p> <p>-The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors;</p> <p>-The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems;</p> <p>-Procedure: The Administrator may delegate coordination and implementation of components of the abuse prevention program to other staff within the facility;</p> <p>-Prevention: Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation;</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Identification: The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect: Physical Abuse: Welts or bruises;</p> <p>-Investigation: The facility promptly and thoroughly investigates reports of resident abuse. The investigation may take some or all of the following steps: An employee who knowingly makes a false report may be subject to disciplinary action, up to and including termination;</p> <p>-Protection: Resident-resident altercations will only be investigated as an incident of abuse if the incident meets the criteria of the definition of abuse (no definition provided);</p> <p>-Residents and facility staff will not be retaliated against for reporting abuse.</p> <p>Review of the Resident #6's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/2/24, showed:</p> <p>-Cognitively intact;</p> <p>-No impairment upper or lower extremity;</p> <p>-Walker;</p> <p>-Depression (other than bipolar disorder).</p> <p>Review of the resident's care plan, in use at the time of the investigation, showed:</p> <p>-Focus: Resident has the potential to demonstrate physical behaviors related to anger and poor impulse control toward staff and other residents;</p> <p>-Goal: Resident will verbalize understanding of need to control physically aggressive behavior;</p> <p>-Interventions:</p> <p>- Analyze key times, places, circumstances, triggers and what de-escalate behavior and document;</p> <p>-Provide physical and verbal cues to alleviate anxiety, positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated;</p> <p>-Give the resident choices about care and activities to help de-escalate the situation;</p> <p>-When the resident becomes agitated, intervene before agitation escalates. Guide away from the source of distress, engage calmly in conversation. If response is aggressive, staff to walk calmly away, and approach later;</p> <p>-Focus: Resident has potential to demonstrate verbally abusive behaviors related to ineffective coping skills and poor impulse control;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Goal: Resident will verbalize understanding of need to control verbally abusive behavior;</p> <p>-Interventions included:</p> <p>-Assess resident's understanding of the situation. Allow time for the resident to express self and feelings toward the situation;</p> <p>-Give choices of care and activities to de-escalate the situation;</p> <p>-When the resident becomes agitated, intervene before agitation escalates. Guide away from the source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later.</p> <p>Review of Resident #8's admission MDS, dated [DATE], showed:</p> <p>-Severe cognitive impairment;</p> <p>-Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abuses others, sexually): Behavior of this type occurs daily;</p> <p>-Wheelchair;</p> <p>-Diagnoses included stroke.</p> <p>Review of the resident's care plan in use at the time of the investigation, showed:</p> <p>-Focus: Resident has potential to be physically aggressive related to poor impulse control, throwing things at staff and attempting to trip staff and other residents by putting his/her feet out;</p> <p>-Goal: Resident will verbalize understanding of need to control physically aggressive behavior through the review date;</p> <p>-Interventions/Tasks: Maintain and keep resident safe and prevent harm to other residents. Monitor and document observed behavior and attempted interventions in behavior log. Monitor/document/report as need any signs/symptoms of resident posing danger to self and others.</p> <p>Review of Resident #5's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abuses others, sexually): Behavior not exhibited;</p> <p>-No impairments upper/lower extremity;</p> <p>-Walker;</p> <p>-Diagnoses included: Hypertension and Alzheimer's Disease.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's alert note, showed on 2/25/25 at 2:27 P.M., the resident was placed on 1:1 for choking another resident (Resident #6).</p> <p>Review of Resident #5's social service note, showed on 2/25/25 at 4:23 P.M., at 10 A.M., Resident #5 was engaged in an altercation with another resident. Nursing staff and aides promptly intervened to de-escalate the situation, providing verbal redirection and emotional support. This afternoon, the Social Worker met with the resident to discuss the physical altercation that occurred earlier on 2/25/25. The resident was given the opportunity to share his/her perspective on the incident. The Social Worker reviewed the importance of personal boundaries and discussed the impact of physical aggression on others and the overall community. He/She was encouraged to seek staff assistance or remove himself/herself from escalating situations to prevent further conflicts. The Social Worker provided education on the facility's behavioral expectations and the consequences of physical aggression.</p> <p>Review of Resident #5's general progress note, showed on 2/25/25 at 4:28 P.M., PCP on rounds and resident assessed. New orders received for psychiatric evaluation for patient-to-patient altercation for safety evaluation.</p> <p>Review of the facility's investigation summary provided by RNC, dated 2/26/25, showed:</p> <ul style="list-style-type: none"> <li>-It was alleged that during a smoke break on 2/25/25, Resident #6 and Resident #5, who know each other well from the facility and are friends, were conversing. Suddenly, without provocation, Resident #5, who was sitting across from Resident #6, extended his/her arms and placed his/her hands around Resident #6's neck. Staff immediately took the following actions:</li> <li>-Staff immediately intervened and separated the two residents to ensure safety;</li> <li>-A licensed nurse assessed both residents, and no injuries were noted;</li> <li>-Resident #6 stated he/she was unsure what provoked this behavior, as they are friends and it happened without apparent cause;</li> <li>-When interviewing Resident #5, he/she did not recall what occurred;</li> <li>-Resident #5 is cognitively intact.</li> </ul> <p>During an interview on 2/26/25 at 11:23 A.M., Resident #5 said he/she knew Resident #6 and they were friends. He/She said Resident #6 cussed him/her out yesterday. He/She said Resident #6 came into his/her room and started cussing him/her out. Resident #6 wanted everything his/her way. He/She didn't get hurt but did push Resident #6 back because he/she was in his/her face talking about people's mama and stuff. Resident #6 cussed people out bad and staff let him/her get away with a lot of stuff. He/She said Resident #6 thinks he/she can say anything to people.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/4/25 at 9:53 A.M., Resident #6 said Resident #5 liked him/her but they were just friends. He/She wanted to stay just friends, nothing else. Resident #5 saw him/her talking to a new resident. He/She said Resident #5 called the new resident a honky. He/She said Resident #5 choked him/her because Resident #5 was jealous. That was the only time Resident #5 choked him/her. Resident #6 and Resident #5 were arguing in the hallway as he/she was going outside to smoke a cigarette. He/She said Resident #5 didn't choke him/her until they got outside. There were aides in the hallway when they were arguing but only one of them said hey hey, what's the arguing about? No one came over to where he/she and Resident #5 were. He/She said Resident #5 told him/her to keep talking smart and if talking smart when they got outside, See what happens. He/She told Resident #5 he/she was going outside to smoke. He/She said there was bruising on his/her neck and his/her throat was sore after Resident #5 choked him/her. He/She demonstrated the choking by placing his/her thumb on one side of his/her neck, near his/her throat and his/her fingers around the neck on the other side. He/She said some residents and staff pushed Resident #5 off him/her. He/She left the patio and went to his/her room. Staff said he/she had to go to the hospital. He/She told staff Resident #5 choked him/her so why did he/she have to go? He/She said staff told him/her that was protocol. The aides kept asking him/her if he/she was ok. He/She thought there was only one other resident outside when Resident #5 choked him/her, but staff ran outside to help get Resident #5 off him/her. He/She saw the doctor at the facility. He asked if he/she was ok and didn't say anything else. He/She went to the hospital. The resident felt safe because they moved Resident #5 farther down the hall. He/She was not worried about Resident #5. He/She kept his/her distance from Resident #5 and Resident #5 has kept his/her distance from him/her. He/She said Resident #5 was his/her friend, but not now. He/She doesn't look Resident # 5's way and doesn't talk to him/her anymore. He/She doesn't trust Resident #5 anymore because he/she did him/her like that, grabbing him/her by his/her throat. He/She said Resident #5 grabbed him/her like he/she was trying to kill him/her or something. He/She said as little as he/she was, Resident #5 would grab him/her by the throat. That let him/her know where he/she was coming from. He/She said their friendship was a done deal (not friends). He/She was friendly. It made him/her upset when people got up in his/her face. Resident #6 left with his/her family because that's how upset he/she was. He/She couldn't fight. He/She was too old for that. He/She couldn't tussle and Resident #5 was big compared to him/her.</p> <p>During an interview on 2/25/25 at 2:15 P.M., the Social Service Manager said Resident #6 and Resident #5 didn't have a history of resident-to-resident abuse with each other or other residents. She said the residents had arguments with each other before but nothing like this.</p> <p>During an interview on 2/26/25 at 1:09 P.M., the Social Service Manager said she had just learned of the information about yesterday when she took Resident #6 to his/her room. The resident said Resident #5 put his/her hands on him/her. She talked with Resident #5 in his/her room. She said Resident #5 said he/she never touched Resident #6. The information Resident #5 told her was different than what everyone else said. Resident #5 told her he/she just pushed Resident #6 but didn't touch his/her neck. She informed the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/25 at 11:59 A.M., Nursing Assistant (NA) C said he/she was at work yesterday and was assigned to Resident #6. Resident #5 lived on the same hall . The Resident #6 was outside on the patio. He/She started cussing and swung on Resident #5. Resident #5 tried to stop the resident from hitting him/her. NA C and another staff separated Resident #6 and Resident #5. They told the DON what happened and wrote statements. Resident #6 was fussing at Resident #5 and getting all up in his/her face. Then, the resident Resident #6 hit Resident #5. Resident #5 put his/her hands up. It looked like he/she hit the resident Resident #6. Resident #5 put his/her hands up to stop Resident #6 from hitting him/her. It wasn't a fight or anything like that.</p> <p>During an interview on 3/4/25 at 11:30 A.M., NA C said he/she didn't hear any argument between Resident #6 and Resident #5. Resident #6 was out on the patio first, then Resident #5 came out. Both were smoking. He/She didn't think there were other residents out there besides those two residents, but there could have been one other resident. He/She wasn't sure. He/She didn't know Resident #6 and Resident #5 were coupled up or dating. He/She just knew they were friends. He/She saw Resident #5 hit Resident #6 but not choke. At first, they were arguing outside. Then it escalated. Resident #6 hit Resident #5, then Resident #5 hit Resident #6 back. Resident #5 told Resident #6, you suck other people's dick. Resident #5 said other things to Resident #6 but he/she didn't hear it all. He/She just tried to keep them separated. He/She didn't know anything about Resident #6 and Resident #8's altercation.</p> <p>During a telephone interview on 3/3/25 at 12:36 P.M., the Social Worker Manager thought nursing staff took Resident #6 to the patio to calm down and that's where the altercation with Resident #5 happened. Resident #6 and staff told her the altercation happened on the patio but Resident #5 said it happened in his/her room. She wasn't completely dependent upon what Resident #5 said but it was false based on what everyone else said. Based on what she saw, there were two staff with Resident #6 and Resident #5 was taken back to his/her room. The door was closed. She said Resident #5 said Resident #6 tried to ask him/her for money and he/she said no. Resident #6 said he/she and Resident #5 were friends, but he/she didn't want it to be more than that. From what she understands, Resident #6 was in a heightened state that morning due to something else. She thinks the staff did their job related to the incident between Resident #6 and Resident #8. She didn't think the staff thought Resident #6 would escalate so fast. What happened that day, she didn't think anybody was used to Resident #6 getting escalated to that point. She said the resident was a calm, strict, and firm person.</p> <p>During a telephone interview on 3/3/25 at 3:39 P.M., the PCP said he was aware of the choking incident between Resident #5 and Resident #6. He was told the residents were girlfriend/boyfriend but he wasn't sure.</p> <p>During an interview on 3/4/25 at 11:53 A.M., the ADON said the Resident #6 had bruises on his/her neck. Resident #5 snatched (grabbing someone fast and with force) him/her up. He/She said Resident #6 was already upset from the night before. He/She said the resident said he/she had been upset all night and woke up this morning still upset. Resident #6 went out on the patio. He/She was cussing at Resident #5. Resident #5 picked Resident #6 up by the neck. The ADON said you can't agitate these residents because it takes a long time to calm them down.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46970</p> <p>Based on interview and record review, the facility failed to provide the necessary behavioral health care services when staff did not intervene during a resident's agitated and heightened state (Resident #6) who then kicked another resident (Resident #8). The facility also failed to intervene when Residents #6 and #5 were involved in a verbal altercation that led to Resident #5 reaching out and wrapping his/her hands around Resident #6's neck. Resident #6 complained of bruising to his/her neck and a sore throat. The sample was 8. The census was 87.</p> <p>Review of the facility's Behavior Management policy, revised 06/2020, showed:</p> <ul style="list-style-type: none"> <li>-Purpose: To implement the most desirable and effective interventions to change, modify, decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the resident's quality of life;</li> <li>-The facility is responsible for providing behavioral health care and services that create an environment that promotes emotional and psychosocial well-being meet each resident's needs and include individualized approaches to care;</li> <li>-Policy: The concept of behavior management is an interdisciplinary process. The key components of this process are: <ul style="list-style-type: none"> <li>-Identifying residents whose behaviors may pose a risk to self or others;</li> <li>-Developing individual and practical care strategies based on assessed needs;</li> <li>-Implementing the behavior management program;</li> <li>-Ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program;</li> </ul> </li> <li>-The goal of any behavior management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify behavior management issues and develop an effective management program;</li> <li>-The charge nurse will assign a staff member(s) to monitor/shadow the resident as needed.</li> </ul> <p>Review of the Resident #6's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/2/24, showed:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-No impairment upper or lower extremity;</li> <li>-Walker; and</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Sage Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  3421 Gasconade Saint Louis, MO 63118	
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Depression (other than bipolar disorder).</p> <p>Review of the resident's care plan in use at the time of the investigation, showed:</p> <p>-Focus: Resident has the potential to demonstrate physical behaviors related to anger and poor impulse control toward staff and other residents;</p> <p>-Goal: Resident will verbalize understanding of need to control physically aggressive behavior;</p> <p>-Interventions/Tasks: Analyze of key times, places, circumstances, triggers, and what de-escalate behavior and document;</p> <p>-Provide physical and verbal cues to alleviate anxiety, positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated;</p> <p>-Give the resident choices about care and activities to help de-escalate the situation;</p> <p>-When the resident becomes agitated, intervene before agitation escalates. Guide away from the source of distress, engage calmly in conversation. If response is aggressive, staff to walk calmly away, and approach later;</p> <p>-Focus: Resident has potential to demonstrate verbally abusive behaviors related to ineffective coping skills and poor impulse control;</p> <p>-Goal: Resident will verbalize understanding of need to control verbally abusive behavior;</p> <p>-Interventions included:</p> <p>-Assess and anticipate resident's needs;</p> <p>-Assess resident's coping skills and support system;</p> <p>-Assess resident's understanding of the situation. Allow time for the resident to express self and feelings toward the situation;</p> <p>-Give choices of care and activities to de-escalate the situation;</p> <p>-Provide positive feedback for good behavior and emphasize the positive aspects of compliance;</p> <p>-When the resident becomes agitated, intervene before agitation escalates. Guide away from the source of distress. Engage calmly in conversation. If response is aggressive, staff to walk calmly away and approach later.</p> <p>Review of Resident #8's admission MDS, dated [DATE], showed:</p> <p>-Severely impaired;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abuses others, sexually): Behavior of this type occurs daily;</p> <p>-Wheelchair;</p> <p>-Diagnoses included stroke.</p> <p>Review of the resident's care plan in use at the time of the investigation, showed:</p> <p>-Focus: Resident has potential to be physically aggressive related to poor impulse control, throwing things at staff and attempting to trip staff and other residents by putting his/her feet out;</p> <p>-Goal: Resident will verbalize understanding of need to control physically aggressive behavior through the review date;</p> <p>-Interventions/Tasks: Maintain and keep resident safe and prevent harm to other residents. Monitor and document observed behavior and attempted interventions in behavior log. Monitor/document/report as need any signs/symptoms of resident posing danger to self and others.</p> <p>Review of Resident #5's quarterly MDS, dated [DATE], showed:</p> <p>-Cognitively intact;</p> <p>-Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abuses others, sexually): Behavior not exhibited;</p> <p>-No impairments upper/lower extremity;</p> <p>-Walker;</p> <p>-Diagnoses included: Hypertension and Alzheimer's Disease.</p> <p>Review of the resident's care plan in use at the time of the investigation, showed:</p> <p>-Focus: The resident has potential to demonstrate physical behaviors related to Dementia;</p> <p>-Goal: The resident will verbalize understanding of need to control physically aggressive behavior through the review date;</p> <p>-Interventions included:</p> <p>-Analyze of key times, places, circumstances, triggers, and what de-escalated behavior and document;</p> <p>-Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated;</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitor. Document observed behavior and attempted interventions in behavior log;</p> <p>-When the resident becomes agitated: Intervene before agitation escalates; Guide away from the source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away and approach later.</p> <p>Review of Resident #6's mood/behavior note, showed:</p> <p>- On 1/1/25 at 11:58 A.M., today this resident was complaining of having his/her gold chain stolen. He/She came out in the hall and said his/her chain was stolen and muthafuckers are going to find his/her shit! He/She then went to a resident that was sitting in the hall and said to him/her, I know you took my shit because yo sneaky ass always by my door! If my shit don't come up, it's gone be a problem! Resident then went to three other resident's doors and stated, come the fuck out here and find my shit! Other residents were saying they did not have the chain for the resident to go back into his/her room and look for it. He/She was calling staff out of their names, stating staff don't do anything for him/her at all. The resident went back into his/her room and found the box with his/her gold chain in the closet in one of his/her jacket pockets. He/She then came out and stated he/she was sorry everyone, he/she found the gold chain. This nurse reached out to administration who came to assist with the situation. Also called 911 for assistance with the resident and calming down the situation. The resident left the facility for two nights to go with his/her family;</p> <p>-On 1/18/25 at 11:18 A.M., during this shift, resident yelling at this nurse, cursing, and displaying erratic behavior. Resident appeared to be upset due to him/her having to wait for this nurse to complete his/her treatment. The other nurse that was present notified resident that this nurse would be doing his/her treatment. He/She then appeared to be agitated and visibly upset. This nurse informed the resident his/her treatment would be started as soon as this nurse took his/her personal items away. He/She then started saying that he/she was ready and that the nurse needed to be ready. The resident then proceeded to walk towards this nurse yelling and cursing, calling the nurse a fake bitch and also said the nurse thought the resident was cute. The resident yelled at this nurse saying, with all the at fake shit. At this time, this nurse feels unsafe working with this resident. The resident has created a hostile work environment.</p> <p>Review of Resident #6's alert note, showed:</p> <p>-2/25/25 at 12:59 P.M., the resident was upset this a.m. The resident stated he/she spent the entire night upset. The resident yelling at everyone but he/she was not combative at that moment. Staff stated the resident walked up to another resident (Resident #8) and kicked that resident's leg. This nurse called 911 and paramedics to assist with calming resident down to prevent him/her from fighting other residents. Police arrived and stated they could not take him/her since he/she had calmed and refused to go. The police stated it would be involuntary due to him/her being his/her own responsible party. The resident went outside, exchanged words with another resident, who then wrapped his/her hands around the resident's neck and choked him/her, leaving visible marks. Resident stated he/she was not going to the hospital under no circumstances. He/She refused vital signs and stated he/she wanted to speak with the Social Worker only. The Social Worker arrived, and the resident went to his/her room with the Social Worker;</p> <p>-2/25/25 at 2:26 P.M., resident placed on 1:1 immediately after for his/her and other residents safety.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #8's alert note, showed on 2/25/25 at 5:39 P.M., resident kicked by another resident in his/her leg, per staff. Primary Care Physician (PCP) assessed resident and stated he/she had no injuries. No bruising noted. Resident has no complaints of pain or discomfort. Resident unable to tell this nurse what happened and why he/she was kicked. Guardian made aware via phone.</p> <p>Review of the facility's investigation summary, dated 2/25/25, signed by Regional Nurse Consultant (RNC), showed:</p> <ul style="list-style-type: none"> <li>-Incident description: During breakfast on 2/25/25, Resident #6 expressed his/her discontent about the meal and stood up, gesturing with his/her arms. In doing so, he/she inadvertently made contact with Resident #8's anterior (outer) thigh;</li> <li>-Immediate actions taken:</li> <li>-Staff promptly intervened and separated the two residents to ensure their safety;</li> <li>-Both residents were assessed for injuries by a licensed nurse (none noted);</li> <li>-Notifications were made to the Administrator, Director of Nursing (DON), Regional RNC, Regional Director of Operations (RDO), PCP, Responsible party (RPs), Department of Health and Senior Services, and Police Department;</li> <li>-Interviews were conducted with both residents and staff;</li> <li>-Trauma-informed screenings were performed for Resident #8, Resident #6, and all other residents in the dining room;</li> <li>-Safe surveys were conducted with all residents on the unit with a Brief Interview for Mental Status (BIMS) score above 8;</li> <li>-Both residents' plan of care, care plans, and progress notes were reviewed;</li> <li>-Both residents' PCPs were seen onsite, and orders were obtained;</li> <li>-Both residents' were placed under direct close supervision;</li> </ul> <p>-Follow-up action: On 2/25/25, the DON and Administrator interviewed both residents. Resident #8 could not recall the event. Resident #6 adamantly denied any willful intent to strike Resident #8, explaining that he/she was merely expressing his/her discontent with the meal and accidentally made contact while gesturing. He/She emphasized that he/she did not intend to cause any harm, injury, or pain to Resident #8. Resident #8 was unable to recall the event. Resident #6 remained on 1:1 supervision, but it was lowered at this time due to the investigation deeming it was not abuse. However, he/she continued to be monitored to ensure safety.</p> <p>Review of the resident's alert note, dated 2/25/25 at 2:26 P.M., showed:</p> <ul style="list-style-type: none"> <li>-Patient placed on 1:1 immediately after for his/her and other residents safety;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-No other documented interventions during the residents agitated state and/or prior to the altercation.</p> <p>Review of the resident's social service note, dated 2/25/25 at 3:00 P.M., showed at 10:00 A.M. in the morning, the resident (Resident #6) appeared agitated and displayed signs of distress, leading to a verbal altercation with another resident.</p> <p>During an interview on 3/3/25 at 12:36, the Social Worker said nursing staff and aides promptly intervened to de-escalate the situation, providing verbal redirection and emotional support. Staff stopped Resident #6 from making things worse. She would consider the ideal thing to do was to keep Resident #6 away from Resident #8 and that's what happened. She expected staff to be proactive. If staff saw Resident #6 was screaming, agitated, and/or acting erratic, the staff should have intervened then. She said the staff actions with Resident #6 should have happened prior to the altercation with Resident #8.</p> <p>During a telephone interview on 3/3/25 at 3:39 P.M., the facility physician said he was notified Resident #8 had been kicked in the leg. He assessed the resident, and he/she had no bruising to the leg.</p> <p>During an interview on 3/4/25 at 11:53 A.M., the ADON said Resident #6 kicked Resident #8 in the leg. He/She was standing in the doorway behind nurse's station when he/she heard staff asking Resident #6 why he/she kicked Resident #8.</p> <p>Review of Resident #6's alert note, showed on 2/25/25 at 12:59 P.M., the resident was yelling at everyone about the food issues, but he/she was not combative at that moment. He/She went outside, exchanged words with another resident (Resident #5), who then wrapped his/her hands around the resident's neck and choked him/her, leaving visible marks.</p> <p>Review of the Resident #6's social service note, showed 2/25/25 at 3 P.M., at 10 A.M., in the morning, the resident appeared agitated and displayed signs of distress, leading to a verbal altercation with another resident. Nursing staff and aides promptly intervened to de-escalate the situation, providing verbal redirection and emotional support. The resident was encouraged to take deep breaths and step away from the situation to regain composure.</p> <p>Review of the Resident #6's general progress note, dated 2/25/25 at 8:45 P.M., showed the resident agreed to go to the hospital for psychiatric evaluation. [NAME] noted to neck area.</p> <p>Review of Resident #5's alert note, showed on 2/25/25 at 2:27 P.M., resident placed on 1:1 for choking another resident (Resident #6).</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's social service note, dated 2/25/25 at 4:23 P.M., showed at 10:00 A.M., the resident was engaged in an altercation with another resident (Resident #6). Nursing staff and aides promptly intervened to de-escalate the situation, providing verbal redirection and emotional support. This afternoon, the social worker met with the resident to discuss the physical altercation that occurred earlier on 2/25/25. The resident was given the opportunity to share his/her perspective on the incident. The social worker reviewed the importance of personal boundaries and discussed the impact of physical aggression on others and the overall community. He/She was encouraged to seek staff assistance or remove himself/herself from escalating situations to prevent further conflicts. The social worker provided education on the facility's behavioral expectations and the consequences of physical aggression.</p> <p>Review of the Resident #5's general progress note, showed on 2/25/25 at 4:28 P.M., PCP on rounds and resident assessed. New orders received for psychiatric evaluation for patient-to-patient altercation for safety evaluation.</p> <p>Review of the facility's investigation summary provided by RNC, dated 2/26/25, showed:</p> <ul style="list-style-type: none"> <li>-It was alleged that during a smoke break on 2/25/25, Resident #6 and Resident #5, who know each other well from the facility and are friends, were conversing. Suddenly, without provocation, Resident #5, who was sitting across from Resident #6, extended his/her arms and placed his/her hands around Resident #6's neck. Staff immediately took the following actions:</li> <li>-Staff immediately intervened and separated the two residents to ensure safety;</li> <li>-A licensed nurse assessed both residents, and no injuries were noted;</li> <li>-Resident #6 stated he/she was unsure what provoked this behavior, as they are friends and it happened without apparent cause;</li> <li>-When interviewing Resident #5, he/she did not recall what occurred;</li> <li>-Resident #5's BIMS score of 14 and is cognitively intact.</li> </ul> <p>During an interview on 2/26/25 at 11:23 A.M., Resident #5 said he/she knew Resident #6 and they were friends. He/She said Resident #6 cussed him/her out on yesterday. He/She said Resident #6 came into his/her room and started cussing him/her out. Resident #6 wanted everything his/her way. He/She didn't get hurt but did push the resident back because Resident #6 was in his/her face talking about people's mama and stuff. Resident #6 cussed people out bad and staff let him/her get away with a lot of stuff. He/She said Resident #6 thinks he/she can say anything to people.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/4/25 at 9:53 A.M., Resident #6 said Resident #5 said he/she liked Resident #6, but they were just friends. He/She wanted to stay just friends, nothing else. Resident #5 saw him/her talking to a new resident. He/She said Resident #5 called the new resident a honky. Resident #5 choked him/her because he/she was jealous. That was the only time he/she choked him/her. The two residents were arguing in the hallway as he/she was going outside to smoke a cigarette. Resident #5 didn't choke him/her until they got outside. There were aides in the hallway when they were arguing but only one of them said hey hey, what's the arguing about? No one came over to where he/she and Resident #5 were. Resident #5 told him/her to keep talking smart and if he/she talked smart when they got outside, See what happens. He/She told Resident #5 he/she was going outside to smoke. There was bruising on his/her neck and his/her throat was sore after Resident #5 choked him/her. He/She demonstrated the choking by placing his/her thumb on one side of his/her neck, near his/her throat and the rest of his/her fingers around the neck on the other side. He/She said some residents and staff pushed Resident #5 off him/her. He/She left the patio and went to his/her room. Staff said he/she had to go to the hospital. He/She told staff Resident #5 choked him/her so why did he/she have to go? Staff said it was protocol. The aides kept asking if he/she was ok? He/She thought there was only one other resident outside when Resident #5 choked him/her, but staff ran outside to help get Resident #5 off him/her. He/She saw the doctor at the facility. He asked if he/she was ok and didn't say anything else. He/She went to the hospital. He/She felt safe because they moved Resident #5 farther down the hall. He/She was not worried about him/her. He/She kept his/her distance from Resident #5 and Resident #5 has kept his/her distance from Resident #6. Resident #5 was a friend, but not now. He/She didn't look Resident #5's way and didn't talk to him/her anymore. He/She doesn't trust Resident #5 anymore because he/she grabbed him/her by the throat. Resident #5 grabbed like he/she was trying to kill him/her or something. He/She said as little as he/she was, Resident #5 would grab him/her by the throat. That let him/her know where Resident #5 was coming from. He/She said their friendship had ended. Resident #6 was friendly. It made him/her upset when people get up in his/her face. He/She left with his/her family because that's how upset he/she was. Resident #6 said he/she couldn't fight or tussle. He/She was too old for that. Resident #5 was big compared to him/her.</p> <p>During an interview on 2/25/25 at 2:15 P.M., the Social Service Manager said Resident #6 and Resident #5 didn't have a history of resident-to-resident abuse with each other or other residents. She said the residents had arguments with each other before but nothing like this.</p> <p>During an interview on 2/26/25 at 11:59 A.M., Nursing Assistant (NA) C said he/she was at work yesterday and was assigned to the resident's hall. The resident was outside on the patio. He/She started cussing and swung on Resident #5. Resident #5 tried to stop the resident from hitting him/her. NA C and another staff separated the two residents. They told the DON what happened and wrote statements. The resident was fussing at Resident #5 and getting all up in his/her face. Then, the resident hit Resident #5. Resident #5 put his/her hands up. It looked like he/she hit the resident (Resident #6). Resident #5 put his/her hands up to stop the resident (Resident #6) from hitting him/her. It wasn't a fight or anything like that.</p> <p>During an interview on 2/26/25 at 1:09 P.M., the Social Service Manager said she had just learned of the information about yesterday when she took the resident to his/her room. The resident (Resident #6) said Resident #5 put his/her hands on his/her. She talked with Resident #5 in his/her room. She said Resident #5 said he/she never touched Resident #6. The information Resident #5 told her was different than what everyone else said. Resident #5 told her he/she just pushed Resident #6 but didn't touch his/her neck. She informed the administrator.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/25 at 2:41 P.M., Certified Nursing Assistant/Certified Medication Technician (CNA/CMT) D said he/she never had a problem with the resident. He/She didn't know what the resident's interventions were and the resident had not had any outburst since he/she had been there.</p> <p>During an interview on 2/26/25 at 4:23 P.M., CMT A said he/she was fairly new to the floor and was not very familiar with the resident. CMT A said he/she got a walk through and was given paperwork during orientation about the residents. She didn't know of any interventions for the resident but said she would ask a nurse and use whatever resources that were available. CMT A said he/she would be responsible to intervene if the resident became agitated and escalated, even though he/she was fairly new. CMT A said it depended on the situation, but he/she would separate and make the resident 1:1. CMT A said he/she would use common sense but he/she should know what the resident's interventions were. He/She said he/she was sure there were interventions listed but he/she didn't know what they were.</p> <p>During an interview on 2/26/25 at 4:25 P.M., CNA B said he/she knew the resident and he/she did pretty much for himself/herself. CNA B reported the resident's concerns and encouraged him/her to do the same. He/She walked the resident to his/her room to calm him/her down. Sometimes that worked and sometimes it didn't. CNA B said he/she tried to separate the resident from the situation. That was the only intervention he/she was aware of. He/She wasn't aware of all the resident's other interventions but said he/she would ask the nurse, peers, or look in the resident's care plan.</p> <p>During an interview on 2/27/25 at 10:32 A.M., the DON said staff knew what the resident's interventions were because the facility in-serviced staff after the first resident-to-resident altercation. She said the resident was never 1:1 and the documentation in the resident's progress note was not accurate. She said the documentation in the resident's progress note related to kicking the first resident-to-resident altercation was not accurate. She would have both documentations removed from the resident's record. The facility had an immediate huddle and in-service the same day related to the resident's interventions after the first altercation. She and other presenters read the resident's interventions verbatim. They will have to re-in-service staff again on the resident's interventions. The facility gave monthly de-escalation in-services. The resident went out for psychiatric evaluation. She was told the resident was not a threat to self or others. She expected staff to know how to intervene when the resident displayed verbal/physical agitation and expected staff to intervene before the resident's behavior escalated.</p> <p>During an interview on 2/27/25 at 10:41 A.M., the Administrator said he expected the staff to follow the resident's interventions. He expected staff to know what to do before the residents behavior escalated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2025
NAME OF PROVIDER OR SUPPLIER  Sage Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  3421 Gasconade Saint Louis, MO 63118	
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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/3/25 at 12:36 P.M., the Social Worker Manager thought nursing staff took Resident #6 to the patio to calm down and that's where the altercation with Resident #5 happened. Resident #6 and staff told her the altercation happened on the patio but Resident #5 said it happened in his/her room. She wasn't completely dependent upon what Resident #5 said but it was false based on what everyone else said. Based on what she saw, there were two staff with Resident #6 and Resident #5 was taken back to his/her room. The door was closed. She said Resident #5 said Resident #6 tried to ask him/her for money and he/she said no. Resident #6 said he/she and Resident #5 were friends, but he/she didn't want it to be more than that. From what she understands, Resident #6 was in a heightened state that morning due to something. She thinks the staff did their job related to the incident between Resident #6 and Resident #8. She didn't think the staff thought Resident #6 would escalate so fast. What happened that day, she didn't think anybody was used to Resident #6 getting escalated to that point. She said the resident was a calm person, strict, and firm person.</p> <p>During a telephone interview on 3/3/25 at 1:45 P.M., the DON said staff could have not let Resident #5 and Resident #6 go out on the patio to smoke at the same time, if Resident #6 was still upset. She didn't think the resident was still upset with Resident #5. There was nothing to indicate Resident #5 would have choked Resident #6. No words were passed between them. She said no one saw that coming because of their friendship. It happened so fast. Staff separated them immediately.</p>		