STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to ensure residents were free from physical abuse and failed to follow its policies to prevent resident-to-resident abuse when staff failed to consistently monitor Resident #1 during 15-minute face checks as an intervention for wandering. This contributed to three known resident-to-resident altercations, and had the potential to effect the safety and privacy of all other residents on the secured unit. (Residents #2, #3 and #4). The census was 78. Review of the facility's Abuse, Neglect and Exploitation Policy, revised 4/8/24, showed: -Policy: Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect, and misappropriation of property. Resident must not be subject to abuse by anyone, including but not limited to: facility staff, other residents, consultants or volunteers, staff of other agencies servicing the resident, family members, legal guardians, friends or other individuals; -Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This also includes the depravation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain, physical, mental and psychosocial well-being; -Physical abuse includes, but not limited to hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment; -Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness; -The facility will consider utilization of the following tips for prevention of abuse, neglect, and exploitation of residents: -Train staff in appropriate interventions to deal with aggressive and/or catastrophic reactions by residents; -Observe resident behavior and their reaction to other residents, roommates, and/or tablemates; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-Provide instructions to staff on care needs of residents; -Assess, monitor, and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict or neglect. Utilize facility's abuse/neglect risk assessment and develop care needs according to the findings; -Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses; -Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area and any noted visitors in the area. Obtain witness statements, according to appropriate policy. All statements should be signed and dated by the person making the statement; -The facility will make efforts to protect all residents after alleged abuse, neglect and/or exploitation. Review of the facility's Supervision and Management of Residents with Behaviors policy, reviewed 1/24/24, showed: -Policy: To provide support to team members to maintain safety and security when providing care to our residents who may exhibit behaviors, while treating our residents with dignity, respect, and compassion; -Protocol: -De-escalation education will be provided to team members; -Be aware and be on the lookout for a change in the resident's behaviors; -When a resident is exhibiting anxiety, paranoia, defensive or risky behaviors, staff will respond by using de-escalation techniques: -Maintain a safe distance, 5-6 feet; -Use a clear voice tone; -Use a quiet voice to speak to the resident; -Use relaxed, well-balanced, non-threatening posture, while maintaining tactical awareness; -Be active in helping; -Build hope-resolution if possible; -Focus on their strengths; -Present yourself as a calming influence; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-Use limit setting to provide safe and respectful choices; -Be consistent; -Effective verbal intervention must be: -Specific - precise, explicit and clear; -Concise - short, to the point, simple; -Directive - instructive, communicating clearly what you want to other person to do; -Follow the protocol for a resident-to-resident altercation; -Call a Code Grey immediately on your walkie talkie and/or overhead page; -Staff members on scene will attempt to separate the residents and ensure the safe of all residents, without causing further harem; -The staff member will remain in the area of disruption until further assistance arrives; -If the situation escalates, allow the Charge Nurse of Emergency Medical Service (EMS) personnel to relieve you upon arrival. Review of the Resident-to-Resident Altercation Protocol, revised 01/2022, showed: -Policy: To minimize potential harm to our residents, all staff members of the facility will follow this protocol; -Protocol: -The staff member on the scene of the resident-to-resident altercation will immediately call a Code Grey on the walkie/talkie and/or overhead intercom; -Staff members, on scene, will attempt to separated residents and ensure the safety of all residents; -The staff member will remain in the area of disruption until further assistance arrives; -The responding Charge Nurse will notify the Administrator for further instruction, as well as the Director of Nursing (DON) or designee; -The responding Charge Nurse will notify the Primary Care Physician (PCP) and responsible parties of the residents involved; -The Charge Nurse will obtain statements of all staff who witnessed the event and involved residents; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-Documentation of the resident-to-resident altercation, notification of administrator, DON/designee, and physician and outcome to the event will be done in the eMedical Record (EMR). Review of the facility's Coverage on Secure Units policy, revised 01/2022, showed: -Policy: The facility will ensure appropriate staffing and safety for all residents and staff; -Protocol: -The staffing coordinator/designee and Nurse Leadership will work together to provide consistent coverage of the building and the secure units; -No staff will leave their assignment during their shift without proper coverage in place; -Any facility staff member may cover your assigned unit while you leave for your assigned break, to obtain supplies needed for the unit, etc; -No staff will leave their assignment at the end of their shift, until relief is in place. Review of Resident #1's Face Sheet, showed he/she was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Review of the resident's Aggression Assessment, dated 3/20/24 at 8:50 A.M., showed: -Have you ever had episodes of violence - Yes; -If yes, specify how many - 1 or 2; -What specifically happened - He/She had to defend himself/herself; -Who are the targets of the violent behavior - the person that was after me. Review of the resident's physician order sheet, sheet, showed: -Active order dated 4/12/24: Did the resident demonstrate any behaviors such as wandering, elopement, aggression, agitation, anxiety, suicidal ideations, refusal of care, assessments, and any other behaviors. Please document specific behaviors every shift related to Alzheimer's disease. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/26/24, showed: -Severe cognitive impairment; -Physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - behavior of this type occurred 4 to 6 days; -Wandering - Presence and Frequency: Has the resident wandered - Behavior of this type occurred daily; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-Supervision or touching assistance with bed mobility, eating, and locomotion on the unit; -Diagnoses of Alzheimer's disease, depression, and anxiety. Review of the resident's progress notes, showed: -On 4/1/24 at 10:24 A.M. the resident wandered into another resident room and was in a physical altercation. Resident has multiple bloody scratches on his/her face and neck. Scratches cleaned with normal saline per this reporter. Call placed to Psychiatrist office and Psychiatrist made aware that the resident will be transferred to the hospital. Director of Nursing (DON) made aware; -On 4/1/24 at 11:03 A.M. the resident will no longer be transferred to the hospital. Call placed to the physician, new order received to obtain x-ray of the left pointer finger and hand, all views, which are anatomically not in alignment and swollen; -On 4/3/24 at 4:07 P.M., it was reported to the Social Service Department (SSD) the resident was involved in a physical altercation with another resident after wandering into their room. The resident's Power of Attorney (a legal document that allows someone else to act on your behalf) was informed. He/She thinks resident may need medication adjustment. Nursing staff reached out to psychiatric doctor for possible medication adjustment. POA (Power of attorney) was informed the resident would not be sent out to the hospital and the psychiatric doctor had been contacted and POA said ok. POA was informed the resident had been placed on 15-minute face checks. Staff will continue to monitor the resident's mood and behavior; -On 4/3/24 at 5:20 P.M., the resident remains on 15-minute checks related to wandering. Resident had to be redirected this morning from another resident's room. The resident was laying in another resident's bed; -On 4/5/24 at 3:38 P.M., Resident wanders in others room and up and down the halls without purpose. Resident is consistently redirected; -On 4/5/24 at 9:57 P.M., the resident remains on 15-minute checks related to wandering. Resident wanders into other resident's rooms. Resident wanders aimlessly through the unit and has to be consistently redirected this shift. Review of the facility's self-report, dated 4/1/24 at 10:30 A.M., showed a staff member heard noises coming from a room. As he/she arrived, he/she saw a resident trying to leave the side of the room that Resident #3 was located on. It appeared that an altercation had happened between Resident #1 and Resident #3. Resident #1 stated that he/she went into the room that wasn't his/hers by mistake. He/She said Resident #3 started hitting Resident #1 when he/she was on his/her bed. Resident #1 started to hit Resident #3 back. The staff member separated the two residents. Resident #3 appeared to have discoloration on the left side of his/her face, with scratches and it appeared to be swollen. There was blood noted as well. Nursing assessed the area and cleansed it. Ice was applied to the left side of his/her face. Resident #3 remained seated at the edge of his/her bed. Resident #1 was taken to his/her room. He/She was assessed. His/Her left hand appeared swollen. New orders were received from the physician to obtain x-rays of Resident #3's face and Resident #1's hand. All pertinent parties were contacted. Both residents were placed on 15-minute checks. Investigation is ongoing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's progress note, dated 5/22/24 at 5:59 P.M., showed at approximately 5:40 P.M., the resident was seen walking out of another resident's room. He/She was alert and responsive. Upon further assessment, the resident's right hand and knuckles were red and slightly swollen. The resident whose room he/she was coming out of stated that the resident hit him/her in the face. Ice applied to the resident's right hand. EMS called, and resident transported to the hospital. All parties notified; -On 5/24/24 at 11 P.M., the resident wandered into the same resident's room three times. He/She was re-directed gently. Review of the facility's final investigation of a resident-to-resident altercation, dated 5/22/24, showed: -On 5/23/24, Resident #1 and Resident #4 returned from the hospital. Resident #1 returned at 1:10 A.M. and Resident #4 at 1:45 A.M. Resident #4 returned with 2 steri-strips (a thin sticky adhesive bandage that can be used to close small cuts and wounds, or to cover surgical incisions) to the right upper cheek area. Resident #1 returned with ace bandage wrapped to his/her right hand. New orders and interventions include the following: -New orders for Depakote Sprinkles (capsule can be opened and sprinkle the medication on soft food) 2 capsules by mouth 3 times a day for mood affective disorder (a mental health condition that causes significant disruptions in a person's emotions); -Trazodone (used to treat depression and sedative) 25 mg by mouth 3 times a day for depression; -Zyprexa 5 mg by mouth every 6 hours as needed for agitation for 14 days with end date of 6/6/24; -Resident #1's room sign was enlarged and made more colorful; -He/She will be utilizing an iPad to engage in music and certain activities for persons living with dementia. He/She will be utilizing the iPad with staff throughout the day. If he/she was able to use the iPad independently, he/she will have the opportunity to use as needed. All parties are aware of the additional new orders and use of the iPad; -On 6/18/24 at 3:29 P.M., the resident remains on 15-minute checks related to wandering. Resident continues to wander in others' room and had to be consistently redirected. Review of the resident's 24 hour, 15-minute check sheet, showed: -No 15-minute face check documentation for the month of April 2024; -No 15-minute face check documentation for the month of May 2024; -No 15-minute face check documentation for 6/1/24 through 6/5/24 and 6/8/24 through 6/11/24. Review of the resident's progress notes, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-On 7/4/24 at 12:15 P.M., the resident was found in a resident's room on top of him/her. Resident currently on every 15-minute face checks. He/She had last been seen at 11:45 A.M. The resident was immediately removed from the room and taken to 300 hall dining area with no injuries present. He/She was easily redirected and was calm. All parties notified. Psychiatric Department will review his/her current medications and make any changes, if needed. Family made aware of the situation. Resident awaiting lunch meal and 15-minute face checks continued; -On 7/4/24 at 9:01 P.M., The resident was placed on 1:1 supervision, per DON; -On 7/9/24 at 3 P.M., the resident wandering the halls, requires frequent redirecting from other resident's private area. Review of the facility's final investigation of a resident-to-resident altercation, dated 7/11/24, showed on 7/4/24, Resident #1 went into Resident #2's room and got in the bed and laid down. Resident #2 was laying in his/her bed resting. Resident #1 startled Resident #2 as he/she laid down on the bed. An altercation occurred. Staff heard the noises and went to the room. They found the residents in an altercation. Residents #1 and #2 were separated and Resident #1 was led out of the room without incident. Both residents were assessed. Resident #1 had no injuries. Resident #2 had a small scratch above his/her right eye. Neurological checks were initiated per protocol. All pertinent parties were notified, including physicians, responsible parties, and the Administrator. New orders received for Resident #1: Ativan (Lorazepam Oral Tablet, works on the brain to relieve symptoms of anxiety) and Trazodone HCL (used to treat depression) was increased. He/She was placed on a 1:1 observation status indefinitely until he/she can be transferred to another facility that can meet his/her needs. Responsible party is aware and will tour places once the referrals accept him/her for admission. Referrals have been sent out to other facilities at this time. Review of LPN (Licensed Practical Nurse) F's facility investigation statement, dated and signed 7/4/24, showed at approximately 12:00 P.M., he/she was just finishing up with a resident and his/her family. When LPN F came out of the room, staff told him/her there was an altercation between Residents #1 and #2. Upon further assessment, it was noted that Resident #2 had a small scratch above his/her right eye with a scant amount of bleeding. Neurological checks were initiated. Review of CMT (Certified Medication Technician) G's facility investigation statement, dated and signed 7/4/24, showed he/she was standing at his/her medication cart. A Certified Nurse Assistant (CNA) yelled down the hall for help. When CMT G entered the room, there was a resident-on-resident altercation. Review of CNA A's facility investigation statement dated and signed 7/12/24, showed CNA A said he/she yelled for help due to Resident #1 and #2 fighting. He/She walked to Resident #1 and #2, so he/she separated them both. He/She took Resident #1 out of the room and told the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/12/24 at 10:32 A.M., the resident's POA said the facility told him/her the resident wandered into another resident's room and ended up hitting that resident in the face. The facility had been doing the same things over and over again. The resident was moved from the front to the back of the hall, was placed on 1:1 but he/she wasn't told about the 1:1. He/She was visiting the resident and noticed a staff person with him/her and asked why. That's when he/she found out about the 1:1 assignment. He/She purchased the resident a TV so he/she could spend more time in his/her room. He/She said there was a care plan meeting scheduled for next week to talk about the 1:1 assignment and the facility told him/her the 1:1 was expensive, so they weren't sure how long the resident would be 1:1. The POA said he/she didn't usually see a lot of activities for the residents but the facility said they had activities. He/She didn't know if that was true. He/She said the staff had to be conscious of the resident's movement because he/she was always moving about. He/She was active before going to the facility. He/She wanted to know where the staff were prior to the resident wandering into Resident #2's room. Resident # 1 was not always the aggressor, but the POA didn't know if he/she was in this incident or not. The only change the facility had made was the 1:1's and moved the resident to the back of the hall. He/She bought the resident an iPad and the facility kept it in the office. He/She didn't know if the resident could even use the iPad and wasn't given an update to know if the iPad was working as a distraction or not. The facility told him/her the resident only used the iPad for music, but wasn't told the resident only liked it for a couple of days and was not longer using it. When asked if the resident could read, the POA said he/she didn't know. The POA said he/she didn't want Resident #1 or any other resident to be hurt. The 1:1's would be the most helpful if there was a way to pay for it. He/She was told the facility had a memory care section and it was small so they could manage the resident's needs more. The POA said he/she couldn't control the resident and the facility knew that, that's why the resident was there. He/She thought the resident's dementia had gotten worse, which could be another issue. The 1:1's made him/her feel better because he/she thought the resident was safer. During an interview on 7/11/24 at 1:39 P.M., the Administrator said the resident's POA had the idea of the iPad as an intervention and got the resident one. He/She liked it for a couple of days but not now. The Administrator said the facility could not meet the resident's needs and can't keep him/her from wandering into other resident's rooms, so they are helping the POA find more suitable places. Review of the resident's care plan, dated 6/23/24, showed: -Problem: resident wanders and gets into other resident's beds related to Alzheimer's disease. On 4/1/24, the resident got into another resident's bed and there was a physical altercation. On 5/22/24, the resident went into another resident's room and there was a physical altercation; -Goal: The resident will demonstrate happiness with daily routine through the review date; -Approaches/Tasks included: -4/1/24: Separate for safety. 15-minute checks times 72 hours for safety, notify psychiatrist and PCP (Primary Care Physician), orders for x-ray of left hand; -5/22/24: Send to hospital for evaluation of right hand, 15-minute checks for safety, notify psychiatrist for medication evaluation, place a larger name sign on colored paper outside the resident's room, redirect as needed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; -Identify patterns of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise, and intervene as appropriate; -Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; -Staff did not document any patterns of wandering; -Staff did not include direction for staff to use the paper with a house and the resident's name printed on it as an intervention for wandering; -Problem: Behaviors - Aggression: the resident has a potential for being a danger to self and others related to a history of behavior, major depressive disorder, anxiety, insomnia, Alzheimer's disease. The resident doesn't like to be touched; -Goal: The resident will have no indications of psychosocial well-being problem by/through review date; -Approaches/Tasks: Consult with Pastoral Care, Social Services, and Psychiatric Services; -Encourage participation from the resident who depends on others to make own decisions; -Provide opportunities for the resident and family to participate in care; -Staff did not document trigger(s) specific to the resident; -Staff did not document it was very important to the resident to go outside whenever the weather permitted; -Staff did not document de-escalation techniques specific to the resident; -Staff did not document staff were to use the iPad as an intervention. -Staff did not document when to use the resident-to-resident altercation protocol; -Staff did not update the resident's care plan to reflection the physical altercation related to wandering into another resident's room on 7/4/24; -Staff did not document 1:1's as an intervention. Review of the resident's 24 hour, 15-minute check sheet, showed: -No 15-minute face check documentation for the month of April 2024; -No 15-minute face check documentation for the month of May 2024; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-No 15-minute face check documentation for 6/1/24 through 6/5/24 and 6/8/24 through 6/11/24. Observation and interview on 7/12/24 at 9:42 A.M., showed Resident #1 was in bed, lying on his/her stomach, but turned to his/her right side while the questions were asked. He/She nodded his/her head when asked if he/she was ok. The resident said he/she was doing the best he/she could. The resident said it wasn't his/her room. Observation and interview on 7/12/24 at 9:41 A.M., showed Resident #2 lay in bed. He/She said he/she had more than a couple scuffles with other residents. He/She didn't remember exactly what happened but just wanted other residents to not come in his/her room, especially if they were thieves. He/She didn't see Resident #1 take anything this last time. He/She didn't have much stuff anyway. During a telephone interview on 7/11/14 at 1:51 P.M., CNA A said he/she knew Resident #1 and #2. He/She went to get them for lunch. When, he/she walked into the room, Resident #1 was on top of Resident #2. Resident #1 hit Resident #2. He/She didn't know what caused Resident #1 to hit Resident #2. He/She wasn't sure if Resident #2 did anything, but Resident #1 wandered into Resident #2 room. Maybe Resident #2 tried to redirect Resident #1 out of his/her room and that's why they had the altercation. Resident #1 walked around a lot. He/She went into the same rooms a lot and needs to be redirected. The staff take turns watching him/her, but they have other residents to watch too. As soon the resident was sat down, he/she was up again. He/She must be redirected a lot. CNA A said he/she had behavioral training at another facility. He/She didn't document any of the resident's wandering behavior but said he/she told the nurse. CNA A was to monitor him/her every 15-minutes, but he/she didn't document on any of the times he/she checked on the resident. That was impossible for two staff to do. During a telephone interview on 7/11/24 at 10:55 A.M., CMT G said he/she didn't see the altercation and was passing medications. He/She heard a CNA yell for help. He/She didn't know the CNA's name but knew the CNA was a new. When he/she got to the room, Resident #1 was on top of Resident #2. Resident #1 just walked around into other resident's rooms. The resident was nice but confused. He/She was not aggressive. You could tell by the resident's voice that he/she was nice. The resident didn't hit people unless they did something to him/her. CMT G said maybe Resident #1 touched Resident #2's snacks, but was not sure. He/She left the room after the residents were separated. There was enough staff in the room by then. During an interview on 7/11/24 at 12:11 P.M., CNA H said he/she didn't know where the 15-minute documentation was but heard the nurse was supposed to do the checks. He/She wasn't sure about that. CNA H said Resident #2 told him/her Resident #1 came into his/her room to steal, so he/she punched Resident #1 and then Resident #1 hit back. CNA A walked into the room to separate the residents. CNA A was scared and didn't do anything. CNA A went to grab Resident #1's arm, but CMT G said don't touch him/her. CNA H said he/she told Resident #1 to leave the room. CNA H said he/she and LPN F asked Resident #2 what happened, and he/she told them Resident #1 walked into his/her room and picked up his/her things, so he/she punched Resident #1. The Assistant Director of Nursing (ADON) was looking for CNA A and asked where he/she was. CNA H said he/she didn't think the 15-minute checks were being done and there were no activities until the last week or so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 7/11/24 at 11:03 A.M., LPN F said he/she was in another resident's room and didn't see what happened but overhead there was an altercation. He/She went to assess Resident #2. He/She had an area above his/her right eye that was bleeding, but not really bad. He/She didn't know who saw the altercation, but the DON, ADON, and nurse supervisor took care of the rest. He/She was not aware of any injuries for Resident #1. LPN F said the residents were not roommates, Resident #1 had a history of wandering behavior, and had a previous altercation with another resident about a month ago. The resident was on 15-minute checks before the altercation and was now 1:1 observation since the altercation. Staff are with him all the time now. Neither resident went to the hospital. During an interview on 7/11/24 at 11:56 A.M., the ADON said she was at the desk and could hear someone hollering. She didn't know the name of the CNA because he/she was new. By the time she got to the room, the CNAs had already gotten Resident #1 off of Resident #2. They were bringing the residents from the room. She looked at Resident #2 and his/her head had a little blood. It was just a scratch. No steri strips or other treatment was provided. She didn't know who the aggressor was but Resident #1 had a history of aggression towards other residents. Resident #1 wandered and the aggression was usually from other residents trying to get Resident #1 out of their rooms. If Resident #1 became aggressive, it was because he/she would defend himself/herself. He/She was on 15-minute checks but since the altercation, had been 1:1 observation. The ADON said the 15-minute checks not/did not work and the resident actually needed someone with him/her all the time to say, this is your room and redirect him/her. The resident would be a 1:1 on every shift until he/she was discharged . She didn't think the resident knew his/her room and didn't think the colored sign with his/her name was working. The facility was just trying things to lessen the wandering. The ADON said the resident didn't use an iPad and she was not sure if there was an iPad in the facility for him/her. She said the resident's care plan had been updated. During an interview on 7/11/24 at 10:14 A.M., CNA C said he/she knew Resident #1 but wasn't at the facility on the day of the altercation. The resident was a wanderer and quite often went into other residents' rooms. He/She would put on the other residents' shoes and clothes. Because of the resident's physical appearance, he/she was more intimidating. Of the residents who wandered on the unit, he/she wandered the most. Recently, the staff were given a list of activities to keep the resident engaged. At first, they were to keep an eye on him/her, but the resident was getting lost because staff weren't really able to do that. The resident would not be the aggressor. He/She said the resident would protect himself/herself if he/she went into another resident's room and the other resident pushed or hit him/her for being in there, but he/she was not the aggressor. CNA C said the resident was on 1:1 supervision but he/she didn't know how long they would be able to keep 1:1 supervision for the resident. He/She said 1:1 supervision would be effective, but they had a staffing shortage and was using agency staff. CNA C said the resident was on 15-minute checks prior to the altercation with Resident #2 because of his/her wandering. The resident had been on 15-minute checks since he/she came to the facility. The other residents didn't like seeing Resident #1 or any other residents in their rooms. CNA C said the resident had been a boxer. The resident was not the aggressor, but he/she would finish it. Resident # 2 was quiet, stayed mostly in his/her room, and was not sociable. Resident #2 had seen Resident #1 in the empty bed in his/her room before and had not gotten upset or had an altercation before. Maybe Resident #2 had a bad day, he/she wasn't sure what happened because he/she wasn't there that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:31 P.M., CNA B said he/she knew Resident #1 and he/she wandered a lot. The resident went into all the other residents' rooms and a few of them would get upset but some didn't. The resident would get into the other residents' beds. He/She moved fast, that's why he/she was put on 1:1 supervision. The nurse, CNAs, and CMTs did the 15-minute checks but CNAs and CMTs reported the checks to the nurse who then signed and documented in a book at the nurse desk. They were told to pay attention to and keep an eye on the resident. The resident had dementia. He/She didn't bother anyone unless they bothered him/her. If the resident said no, he/she meant that. He/She was easily redirected but didn't want to be forced to do anything. The other residents were aware that Resident #1 would fight. It didn't end well for the other residents. Some residents would call for staff and not touch the resident. Those residents had dementia but wouldn't touch Resident #1. Resident #2 was in his/her right mind. CNA B said he/she did not have any behavioral or dementia training from the facility but had training from a psychiatric facility he/she worked at before. CNA B thought the 15-minute checks worked a little but said the resident was fast. He/She thought it was impossible to keep the resident out of other resident rooms but thought the 1:1 supervision and activities was the best thing. During an observation on 7/11/24 at 2:45 P.M., CNA C was 1:1 with the resident. He/She was seated in a chair outside of the resident's door. There was an approximately 8 x 10 turquoise paper, with an image of a house with the resident's name in black lettering underneath. The picture was affixed to the left side of the wall behind the brown railing with only half of the image of the house visible above the railing. The resident's name was not visible and was hidden below the railing. During an interview, CNA C said he/she never used an iPad with the resident and didn't know he/she ever had one. It was hard to keep watch on the resident because most of the time, there was only one or two staff. He/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46970 Based on interview and record review, the facility failed to ensure one resident, with a diagnosis of Alzheimer's disease and known behaviors, attained or maintained his/her highest practicable, mental, and psychosocial well-being (Resident #1). Staff failed to provide increased behavioral monitoring and failed to update the resident's care plan with identified triggers, personalized interventions, and/or meaningful activities focused on the resident's preferences which resulted in a resident-to-resident altercation. The census was 78. Review of the facility's Supervision and Management of Residents with Behaviors policy, reviewed 1/24/24, showed: -Policy: To provide support to team members to maintain safety and security when providing care to our residents who may exhibit behaviors, while treating our residents with dignity, respect and compassion; -Protocol: -De-escalation education will be provided to team members; -The best way to manage resident behaviors is to provide care in a dignified, respectful and compassionate manner; -Be aware and on the lookout for a change in the resident's behaviors or a sign of distress which may include, but is not limited to the following: -Increase in pacing; -Delusions; -When a resident is exhibiting anxiety, paranoia, defensive or risky behaviors, staff will respond by using de-escalation techniques: -Maintain a safe distance; -Use a clear voice tone; -Use a relaxed, well-balanced, non-threatening posture, while maintaining tactical awareness; -Be active in helping; -Build hope-resolution if possible; -Present yourself as the calming influence; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Remove distractions, disruptive or upsetting influences; -Be consistent; -Recognize that a mentally ill person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds, environment - provide careful explanations and instructions; -Effective verbal interventions must be: -Specific; -Concise; -Directive - instructive, communicating clearly what you want the other person to do; -Follow the protocol for a resident-to-resident altercation: -Call a Code Grey (communication that identifies a resident-to-resident altercation)immediately on your walkie talkie and/or overhead page; -Staff members on scene will attempt to separate the residents and ensure the safety of all residents, without causing further harm; -The staff member will remain in the area of disruption until further assistance arrives; -If the situation escalated, allow the Charge Nurse or EMS (Emergency Medical Service) personnel to relieve you upon arrival. Review of the facility's Care Plan Policy, reviewed 1/24/24, showed: -Policy: A care plan shall be used in developing the resident's daily care routine and will be available to the team for review to ensure the best person-centered care is provided to our residents; -Procedure: -The MDS (Minimum Data Set, a federally mandated assessment instrument completed by facility staff) coordinator will review resident medical records and complete appropriate assessments needed to obtain information to complete the admission MDS; -A comprehensive care plan will be generated through collaboration with the Interdisciplinary Team, resident and responsible party, to be completed by the 21st day of admission; -The care plan will reflect a problem, goal and interventions to guide the interdisciplinary team to assist the resident in achieving the desired outcome for a specific problem; -When goals and objectives are not achieved the resident's medical record will be updated and the care plan will be modified accordingly; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The care plan will be accessible to team members for review at any time; -Care plan meetings will be held quarterly with the Interdisciplinary Team, resident and responsible party or guardian. Review of the facility's Strategies for Communication Documentation policy, (no date) showed: -Residents with dementia have a decreased ability to communicate verbally due to perceptual, language and memory deficits. They also have difficulty understanding and interpreting others' communication. There are several strategies that can be utilized to support their understanding and possibilities to interact with others; -Strategies for communication: -Introduce yourself to the resident before conducting any task; -Always explain what you are going to do prior to moving into the resident's personal space to implement care; -Use a calm, reassuring tone of voice; -Provide opportunities for the resident to experience a sense of control; -Provide consistency in the daily routine; -Provide reassurance as necessary; this is usually most effective from a family member or a healthcare provider with whom the resident is familiar and whose role is established; -If the resident can communicate verbally, determine which sense dominates the resident's perception of the world by listening to their descriptive words, then communicate with the resident through his/her preferred sense; this promotes a feeling of trust in the resident; -Use non-threatening posture, position yourself at eye level with the resident and establish eye contact, unless culturally contraindicated; -Do not sneak up on the resident or approach the resident from behind without announcing yourself. Review of Resident #1's Face Sheet, showed he/she was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. Review of the resident's Aggression Assessment, dated 3/20/24 at 8:50 A.M., showed: -Have you ever had episodes of violence - Yes; -If yes, specify how many - 1 or 2; -What specifically happened - He/She had to defend himself/herself; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Who are the targets of the violent behavior - the person that was after me. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff,dated 6/26/24, showed: -Severe cognitive impairment; -Physical behavioral symptoms directed towards others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) - behavior of this type occurred 4 to 6 days; -Wandering - Presence and Frequency: Has the resident wandered - Behavior of this type occurred daily; -Supervision or touching assistance with bed mobility, eating, and locomotion on the unit; -Diagnoses of Alzheimer's disease, depression, and anxiety. Review of the resident's progress notes, showed: -On 4/1/24 at 10:24 A.M. the resident wandered into another resident room and was in a physical altercation. Resident has multiple bloody scratches on his/her face and neck. Scratches cleaned with normal saline per this reporter. Call placed to Psychiatrist office and Psychiatrist made aware that the resident will be transferred to the hospital. Director of Nursing (DON) made aware; -On 4/1/24 at 11:03 A.M. the resident will no longer be transferred to the hospital. Call placed to the physician, new order received to obtain x-ray of the left pointer finger and hand, all views, which are anatomically not in alignment and swollen; -On 4/3/24 at 4:07 P.M., it was reported to the Social Service Department (SSD) the resident was involved in a physical altercation with another resident after wandering into their room. The resident's Power of Attorney (a legal document that allows someone else to act on your behalf) was informed. He/She thinks resident may need medication adjustment. Nursing staff reached out to psychiatric doctor for possible medication adjustment. POA (Power of Attorney) was informed the resident would not be sent out to the hospital and the psychiatric doctor had been contacted and POA said ok. POA was informed the resident had been placed on 15-minute face checks. Staff will continue to monitor the resident's mood and behavior; -On 4/3/24 at 5:20 P.M., the resident remains on 15-minute checks related to wandering. Resident had to be redirected this morning from another resident's room. The resident was laying in another resident's bed; -On 4/5/24 at 3:38 P.M., Resident wanders in others room and up and down the halls without purpose. Resident is consistently redirected; -On 4/5/24 at 9:57 P.M., the resident remains on 15-minute checks related to wandering. Resident wanders into other resident's rooms. Resident wanders aimlessly through the unit and has to be consistently redirected this shift; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/22/24 at 5:59 P.M., at approximately 5:40 P.M., the resident was seen walking out of another resident's room. He/She was alert and responsive. Upon further assessment, the resident's right hand and knuckles were red and slightly swollen. The resident whose room he/she was coming out of stated that Resident #1 hit him/her in the face. Ice applied to the resident's right hand. EMS called, and resident transported to the hospital. All parties notified; -On 5/24/24 at 11 P.M., the resident wandered into the same resident's room three times. He/She was re-directed gently; -On 6/18/24 at 3:29 P.M., the resident remains on 15-minute checks related to wandering. Resident continues to wander in others' room and had to be consistently redirected. Review of the resident's 24 hour, 15-minute check sheet, showed: -No 15-minute face check documentation for the month of April 2024; -No 15-minute face check documentation for the month of May 2024; -No 15-minute face check documentation for 6/1/24 through 6/5/24 and 6/8/24 through 6/11/24. Review of the facility's resident-to-resident altercation investigation, dated 5/22/24, showed: -The resident sign (hung outside the resident's room to indicate it was the resident's room) was enlarged and made more colorful; -The resident was given an iPad to engage in music and certain activities for persons living with dementia. He/She will utilize the iPad with staff throughout the day. If he/she is able to use the iPad independently, he/she will have the opportunity to use as needed. All parties are aware of the use of the iPad. Review of the resident's care plan, dated 6/23/24, showed: -Problem: resident wanders and gets into other resident's beds related to Alzheimer's disease. On 4/1/24, the resident got into another resident's bed and there was a physical altercation. On 5/22/24, the resident went into another resident's room and there was a physical altercation; -Goal: The resident will demonstrate happiness with daily routine through the review date; -Approaches/Tasks included: -4/1/24: Separate for safety. 15-minute checks times 72 hours for safety, notify psychiatrist and PCP (Primary Care Physician), orders for x-ray of left hand; -5/22/24: Send to hospital for evaluation of right hand, 15-minute checks for safety, notify psychiatrist for medication evaluation, place a larger name sign on colored paper outside the resident's room, redirect as needed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; -Identify patterns of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise, and intervene as appropriate; -Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; -Staff did not document any patterns of wandering; -Staff did not include direction for staff to use the paper with a house and the resident's name printed on it as an intervention for wandering; -Problem: Behaviors - Aggression: the resident has a potential for being a danger to self and others related to a history of behavior, major depressive disorder, anxiety, insomnia, Alzheimer's disease. The resident doesn't like to be touched; -Goal: The resident will have no indications of psychosocial well-being problem by/through review date; -Approaches/Tasks: Consult with Pastoral Care, Social Services, and Psychiatric Services; -Encourage participation from the resident who depends on others to make own decisions; -Provide opportunities for the resident and family to participate in care; -Staff did not document trigger(s) specific to the resident; -Staff did not document it was very important to the resident to go outside whenever the weather permitted; -Staff did not document de-escalation techniques specific to the resident; -Staff did not document staff were to use the iPad as an intervention. -Staff did not document when to use the resident-to-resident altercation protocol. Review of the resident's progress notes, showed: -On 7/4/24 at 12:15 P.M., the resident was found in a resident's room on top of him/her. Resident currently on every 15-minute face checks. He/She had last been seen at 11:45 A.M. The resident was immediately removed from the room and taken to 300 hall dining area with no injuries present. He/She was easily redirected and was calm. All parties notified. Psychiatric Department will review his/her current medications and make any changes, if needed. Family made aware of the situation. Resident awaiting lunch meal and 15-minute face checks continued; -On 7/4/24 at 9:01 P.M., The resident was placed on 1:1 supervision, per DON; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265712	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/9/24 at 3 P.M., the resident wandering the halls, requires frequent redirecting from other resident's private area. Review of the facility's resident-to-resident investigation, dated 7/11/24, showed: -On 7/4/24, Resident #1 went into Resident #2's room and got in the bed and laid down. Resident #2 was laying in his/her bed resting. Resident #1 startled Resident #2 as he/she laid down on the bed. An altercation occurred. Staff heard the noises and went to the room. They found the residents in an altercation. Residents #1 and #2 were separated and Resident #1 was led out of the room without incident. Both residents were assessed. Resident #1 had no injuries. Resident #2 had a small scratch above his/her right eye. Neurological checks were initiated per protocol. All pertinent parties were notified, including physicians, responsible parties, and the Administrator. New orders received for Resident #1: Ativan (Lorazepam Oral Tablet, works on the brain to relieve symptoms of anxiety) and Trazodone HCL (used to treat depression) was increased. He/She was placed on a 1:1 observation status indefinitely until he/she can be transferred to another facility that can meet his/her needs. Responsible party is aware and will tour places once the referrals accept him/her for admission. Referrals have been sent out to other facilities at this time. Review of LPN (Licensed Practical Nurse) F's facility investigation statement, dated and signed 7/4/24, showed at approximately 12:00 P.M., he/she was just finishing up with a resident and his/her family. When LPN F came out of the room, staff told him/her there was an altercation between Residents #1 and #2. Upon further assessment, it was noted that Resident #2 had a small scratch above his/her right eye with a scant amount of bleeding. Neurological checks were initiated. Review of CMT (Certified Medication Technician) G's facility investigation statement, dated and signed 7/4/24, showed he/she was standing at his/her medication cart. A Certified Nurse Assistant (CNA) yelled down the hall for help. When CMT G entered the room, there was a resident-on-resident altercation. Review of CNA A's facility investigation statement dated and signed 7/12/24, showed CNA A said he/she yelled for help due to Resident #1 and #2 fighting. He/She walked to Resident #1 and #2, so he/she separated them both. He/She took Resident #1 out of the room and told the nurse. Review of the resident's care plan, showed: -Staff did not update the resident's care plan to reflection the physical altercation related to wandering into another resident's room on 7/4/24; -Staff did not document 1:1's as an intervention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24 at 10:32 A.M., the resident's POA said the facility told him/her the resident wandered into another resident's room and ended up hitting that resident in the face. The facility had been doing the same things over and over again. The resident was moved from the front to the back of the hall, was placed on 1:1 but he/she wasn't told about the 1:1. He/She was visiting the resident and noticed a staff person with him/her and asked why. That's when he/she found out about the 1:1 assignment. He/She purchased the resident a TV so he/she could spend more time in his/her room. He/She said there was a care plan meeting scheduled for next week to talk about the 1:1 assignment and the facility told him/her the 1:1 was expensive, so they weren't sure how long the resident would be 1:1. The POA said he/she didn't usually see a lot of activities for the residents but the facility said they had activities. He/She didn't know if that was true. He/She said the staff had to be conscious of the resident's movement because he/she was always moving about. He/She was active before going to the facility. The POA said the facility had not had any detailed discussions with him/her regarding re-direction or de-escalation, but was told staff had to work it out. The POA said if the facility had three or four staff at certain ends of the floor, that could work out. He/She wanted to know where the staff were prior to the resident wandering into Resident #2's room. Resident # 1 was not always the aggressor, but the POA didn't know if he/she was in this incident or not. The only change the facility had made was the 1:1's and moved the resident to the back of the hall. He/She bought the resident an iPad and the facility kept it in the office. He/She didn't know if the resident could even use the iPad and wasn't given an update to know if the iPad was working as a distraction or not. The facility told him/her the resident only used the iPad for music, but wasn't told the resident only liked it for a couple of days and was not longer using it. When asked if the resident could read, the POA said he/she didn't know. The POA said he/she didn't want Resident #1 or any other resident to be hurt. The 1:1's would be the most helpful if there was a way to pay for it. He/She was told the the facility had a memory care section and it was small so they could manage the resident's needs more. The POA said he/she couldn't control the resident and the facility knew that, that's why the resident was there. He/She thought the resident's dementia had gotten worse, which could be another issue. The 1:1's made him/her feel better because he/she thought the resident was safer. During an interview on 7/11/24 at 1:39 P.M., the Administrator said the resident's POA had the idea of the iPad as an intervention and got the resident one. He/She liked it for a couple of days but not now. The Administrator said the facility could not meet the resident's need and can't keep him/her from wandering into other resident's rooms, so they are helping the POA find more suitable places. During a telephone interview on 7/11/14 at 1:51 P.M., CNA A said he/she knew Resident #1 and #2. He/She went to get them for lunch. When, he/she walked into the room, Resident #1 was on top of Resident #2. Resident #1 hit Resident #2. He/She didn't know what caused Resident #1 to hit Resident #2. He/She wasn't sure if Resident #2 did anything, but Resident #1 wandered into Resident #2 room. Maybe Resident #2 tried to redirect Resident #1 out of his/her room and that's why they had the altercation. Resident #1 walked around a lot. He/She went into the same rooms a lot and needs to be redirected. The staff take turns watching him/her, but they have other residents to watch too. As soon the resident was sat down, he/she was up again. He/She must be redirected a lot. CNA A said he/she had behavioral training at another facility. He/She didn't document any of the resident's wandering behavior but said he/she told the nurse. CNA A was to monitor him/her every 15-minutes, but he/she didn't document on any of the times he/she checked on the resident. That was impossible for two staff to do. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/11/24 at 10:55 A.M., CMT G said he/she didn't see the altercation and was passing medications. He/She heard a CNA yell for help. He/She didn't know the CNA's name but knew the CNA was a new. When he/she got to the room, Resident #1 was on top of Resident #2. Resident #1 just walked around into other resident's rooms. The resident was nice but confused. He/She was not aggressive. You could tell by the resident's voice that he/she was nice. The resident didn't hit people unless they did something to him/her. CMT G said maybe Resident #1 touched Resident #2's snacks, not sure. He/She left the room after the residents were separated. There was enough staff in the room by then. During an interview on 7/11/24 at 12:11 P.M., CNA H said he/she didn't know where the 15-minute documentation was but heard the nurse was supposed to do the checks. He/She wasn't sure about that. CNA H said Resident #2 told him/her Resident #1 came into his/her room to steal, so he/she punched Resident #1 and then Resident #1 hit back. CNA A walked into the room to separate the residents. CNA A was scared and didn't do anything. CNA A went to grab Resident #1's arm, but CMT G said don't touch him/her. CNA H said he/she told Resident #1 to leave the room. CNA H said he/she and LPN F asked Resident #2 what happened, and he/she told them Resident #1 walked into his/her room and picked up his/her things, so he/she punched Resident #1. The Assistant Director of Nursing (ADON) was looking for CNA A and asked where he/she was. CNA H said he/she didn't think the 15-minute checks were being done and there were no activities until the last week or so. During a telephone interview on 7/11/24 at 11:03 A.M., LPN F said he/she was in another resident's room and didn't see what happened but overhead there was an altercation. He/She went to assess Resident #2. He/She had an area above his/her right eye that was bleeding, but not bad. LPN F didn't know who saw the altercation, but the DON, ADON, and nurse supervisor took care of the rest. He/She was not aware of any injuries for Resident #1. LPN F said the residents were not roommates. Resident #1 had a history of wandering behavior, and had a previous altercation with another resident about a month ago. The resident was on 15-minute checks before the altercation and was now on 1:1 observation since the altercation. Staff were with him/her all the time now. Neither resident went to the hospital. During an interview on 7/11/24 at 11:56 A.M., the ADON said she was at the desk and could hear someone hollering. She didn't know the name of the CNA because he/she was new. By the time she got to the room, the CNAs had already gotten Resident #1 off of Resident #2. They were bringing the residents from the room. She looked at Resident #2 and his/her head had a little blood. It was just a scratch. No steri strips or other treatment was provided. She didn't know who the aggressor was but Resident #1 had a history of aggression towards other residents. Resident #1 wandered and the aggression was usually from other residents trying to get Resident #1 out of their rooms. If Resident #1 became aggressive, it was because he/she would defend himself/herself. He/She was on 15-minute checks but since the altercation, had been 1:1 observation. The ADON said the 15-minute checks not/did not work and the resident actually needed someone with him/her all the time to say, this is your room and redirect him/her. The resident would be a 1:1 on every shift until he/she was discharged . She didn't think the resident knew his/her room and didn't think the colored sign with his/her name was working. The facility was just trying things to lessen the wandering. The ADON said the resident didn't use an iPad and she was not sure if there was an iPad in the facility for him/her. She said the resident's care plan had been updated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 10:14 A.M., CNA C said he/she knew Resident #1 but wasn't at the facility on the day of the altercation. The resident was a wanderer and quite often went into other residents' rooms. He/She would put on the other residents' shoes and clothes. Because of the resident's physical appearance, he/she was more intimidating. Of the residents who wandered on the unit, he/she wandered the most. Recently, the staff were given a list of activities to keep the resident engaged. At first, they were to keep an eye on him/her, but the resident was getting lost because staff weren't really able to do that. The resident would not be the aggressor. He/She said the resident would protect himself/herself if he/she went into another resident's room and the other resident pushed or hit him/her for being in there, but he/she was not the aggressor. CNA C said the resident was on 1:1 supervision but he/she didn't know how long they would be able to keep 1:1 supervision for the resident. He/She said 1:1 supervision would be effective, but they had a staffing shortage and was using agency staff. CNA C said the resident was on 15-minute checks prior to the altercation with Resident #2 because of his/her wandering. The resident had been on 15-minute checks since he/she came to the facility. The other residents didn't like seeing Resident #1 or any other residents in their rooms. CNA C said the resident had been a boxer. The resident was not the aggressor, but he/she would finish it. Resident # 2 was quiet, stayed mostly in his/her room, and not sociable. Resident #2 had seen Resident #1 in the empty bed in his/her room before and had not gotten upset or had an altercation before. Maybe Resident #2 had a bad day, he/she wasn't sure what happened because he/she wasn't there that day. During an interview on 7/11/24 at 2:31 P.M., CNA B said he/she knew Resident #1 and he/she wandered a lot. The resident went into all the other residents' rooms and a few of them would get upset but some didn't. The resident would get into the other residents' beds. He/She moved fast, that's why he/she was put on 1:1 supervision. The nurse, CNAs, and CMTs, did the 15-minute checks but CNAs and CMTs reported the checks to the nurse who then signed and documented in a book at the nurse desk. They were told to pay attention to and keep an eye on the resident. The resident had dementia. He/She didn't bother anyone unless they bothered him/her. If the resident said no, he/she meant that. He/She was easily redirected but didn't want to be forced to do anything. The other residents were aware that Resident #1 would fight. It didn't end well for the other residents. Some residents would call for staff and not touch the resident. Those residents had dementia but wouldn't touch Resident #1. Resident #2 was in his/her right mind. CNA B said he/she did not have any behavioral or dementia training from the facility but had training from a psychiatric facility he/she worked at before. CNA B thought the 15-minute checks worked a little but said the resident was fast. He/She thought it was impossible to keep the resident out of other resident rooms but thought the 1:1 supervision and activities was the best thing. During an observation on 7/11/24 at 2:45 P.M., CNA C was 1:1 with the resident. He/She was seated in a chair outside of the resident's door. There was an approximately 8 x 10 turquoise paper, with an image of a house with the resident's name in black lettering underneath. The picture was affixed to the left side of the wall behind the brown railing with only half of the image of the house visible above the railing. The resident's name was not visible and was hidden below the railing. During an interview, CNA C said he/she never used an iPad with the resident and didn't know he/she ever had one. It was hard to keep watch on the resident because most of the time, there was only one or two staff. He/She said there wasn't enough staff and that was the only reason why Resident #1 and Resident #2 got into the altercation. Resident #1 was not the problem. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:49 P.M., LPN D said he/she didn't have any specific abuse, dementia, or behavior training related to Resident #1, but the facility had provided in-service education. Interventions for the resident since the altercation were 1:1 staffing, games, group activities to keep the resident and the other residents busy. When he/she worked, he/she made sure the resident got some TV time in. LPN D thought the 15-minute checks were somewhat working and said if they could redirect the resident before he/she got into other resident's room, he/she wouldn't make them so mad. Then the resident wouldn't have to defend himself/herself for being in other residents' rooms. LPN D said the resident went into all resident rooms and looked for his/her bed to lay down. During an interview on 7/12/24 at 9:27 A.M., Floor Tech E said he/she didn't know the resident but spoke to all of them and that was about it. If he/she saw any resident having behaviors, he/she would let the nurse know, that was the main thing to do. He/She didn't have any abuse, dementia, or behavioral training from the facility. During an interview on 7/12/24 at 9:31 A.M., the Housekeeping Supervisor said she knew all the residents and Resident #1 was quiet until you messed with him/her. She said the resident didn't bother anyone and was not combative, but if someone bothered the resident, he/she would be in defense mode. The floor was a locked unit. She said the resident liked to sing and dance. She said the facility had had trainings for abuse, dementia, and behavior escalation but that's mostly for nursing. She was just there to clean and keep the resident's clothes clean. She let nursing take care of the rest. During an interview on 7/12/24 at 11:07 A.M., CNA H said it was just him/her and LPN F in the back hall. CNA A was supposed to be in the back, but he/she wasn't and that's how the altercation happened. He/She said staff should be present. He/She was in the back by himself/herself. His/Her license was on the line. Observation showed CNA H was tearful and appeared to be frustrated during the interview. During an observation and interview on 7/12/24 at 11:35 A.M., CNA B was seated outside of the resident's room, with the door ajar. During an interview, he/she didn't know if the resident could read. CNA B removed the turquoise sign with the image of a house and resident's name, and presented the sign to the resident. The resident was asked what was on the paper. He/she was asked to say what the picture was. He/She was asked what the words were. Observation showed the resident looked at the turquoise paper and shook his/her head no. The resident did not say, gesture or motion to the image of the house or his/her name. CNA B put the signage back on the wall by the resident's door. During an interview on 7/12/24 at 12:12 P.M., the Activity Director said the facility offered arts and crafts to keep the resident's hands busy. They had music, ice cream socials, puzzles, balloon toss, and dancing. She was aware of the resident's behaviors and heard what happened between Residents #1 and #2. He/She then said she didn't know what the resident's behaviors were. She said the resident liked music, trees, dancing, snacks, singing, and going outside. She didn't have any training on aggressive dementia residents but said if the resident was having behaviors, she would just pull the resident to the side and say, Come on (Resident #1). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265712	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Estates of St Louis, Llc, The	2115 Kappel Drive 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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24 at 12:18 P.M., the Administrator said she didn't know how the signage got down that low on the wall but she raised the sign up during her rounds and put different tape on it so the resident could see it. She expected the sign to have been in the right place before today. She said everyone was responsible to make sure the sign was on the wall and in the right place. The sign was an intervention from a previous altercation. The Administrator said she didn't know what reading level the resident was but thought he/she could read. She said no formal assessment had been completed to see whether he/she could read his/her name or recognize the picture of the house as his/her room. The facil