STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265817	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Circle Rehab and Nursing	2939 Magazine Street Saint Louis, MO 63106

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 - Minimal harm or potential for 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** 34926 Based on interview and record review, the facility failed to ensure a resident's right to be free from abuse was not violated, when one resident was abused by another resident resulting in a cigarette burn to the forehead (Residents #4 and #5). The census was 75. Review of the facility's Abuse and Neglect Policy, dated as revised on August 1, 2022, showed: -Abuse --Willful infliction of injury; -In the case of resident-to-resident interaction, the residents are separated from one another until the investigation has been completed. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/9/23, showed: -Cognitively intact; -No behaviors; -Diagnoses included schizophrenia (a serious mental disorder in which people interpret reality abnormally) and anxiety disorder. Review of the resident's care plan, in use at the time of the incident, showed: -Focus: TOBACCO USE/SMOKING: Resident wishes to smoke/use tobacco products/vape while residing in the facility. Date Initiated: 11/24/23; -Goal: Res will smoke/use tobacco safely in designated areas at designated times through next review. Date Initiated: 11/24/23. Resident will express understanding of and follow smoking/tobacco policies and storage of tobacco related items, through next review. Date Initiated: 11/24/23; -Interventions: (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: 265817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Blue Circle Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2939 Magazine Street Saint Louis, MO 63106	

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	--Educate resident/responsible party (RP) regarding center's smoking policy, designated smoking areas, and storage of smoking materials. Date Initiated: 11/24/23; --Monitor resident's safety during smoking. Report any concerns to charge nurse for further investigation. Date Initiated: 11/24/23; --Provide education as needed on safe smoking practices. Date Initiated: 11/24/23; --Monitor for violations of smoking policy. Report violations to Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON). Date Initiated: 11/24/23; -Focus: The resident is/has potential to be verbally aggressive related to Ineffective coping skills, poor impulse control. Involved in a Resident to Resident verbal altercation. Date Initiated: 02/24/24; -Goal: The resident will demonstrate effective coping skills through the review date. Date Initiated: 2/24/24; -Interventions: --Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 2/24/24; --Assess resident's coping skills and support system. Date Initiated: 2/24/24; --When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date Initiated: 2/24/24. Review of the resident's psychiatry note, date 2/7/24, showed: -Initial psychiatric visit at the facility; -discharged from psychiatric ward on 1/16/24. On 1/3/24, resident was brought in by Emergency Medical Services (EMS) for stealing and fighting with other residents. Resident denied stealing, saying others were stealing from him, and he was in a verbal altercation; -Interval history: Resident admits difficulty in adjusting to living in a facility. Staff reports that he/she can be very rude with staff; -Impression: schizophrenia, paranoid; -Plan: Have spoken with staff, who convey that the resident is behaviorally difficult to manage. Resident does admit that he/she does have a temper. Fluphenazine (an antipsychotic medication used to treat schizophrenia and psychotic symptoms such as hallucinations, delusions, and hostility) injections every two weeks. Review of Resident #5's quarterly MDS, dated [DATE], showed : (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -No behaviors; -Had functional impairment to bilateral (both) upper and lower extremities; -Required a wheelchair for mobility; -Diagnoses included stroke, hemiplegia (paralysis of one side of the body), and moderate protein-calorie malnutrition. Review of the resident's care plan, in use at the time of the incident, showed: -Focus: TOBACCO USE/SMOKING: Resident wishes to smoke/use tobacco products/vape while residing in the facility. Date Initiated: 11/08/23; -Goals: Resident will smoke/use tobacco safely in designated areas at designated times through next review. Date Initiated: 11/08/23. Resident will smoke/use tobacco safely through next review. Date Initiated: 11/08/23. Resident will express understanding of and follow smoking/tobacco policies and storage of tobacco related items, through next review. Date Initiated: 11/08/23; -Interventions: --Complete smoking assessment upon admission/when resident begins to smoke. Reassess as needed with change of condition that affects the ability to smoke. Date Initiated: 11/08/23; --Review smoking policy with resident/ upon admission and PRN (as needed). Date Initiated: 11/08/23; --Monitor resident's safety during smoking. Report any concerns to charge nurse for further investigation. Date Initiated: 11/08/23; -Focus: Resident sustained a cigarette burn to forehead, not self-inflicted. Treatment initiated. Date Initiated: 11/08/23 and revised on: 2/29/24; -Goal: Risks associated with skin integrity will be minimized through review date. Date Initiated: 11/08/23; -Interventions: Complete treatment(s) per order. Monitor any areas of skin impairment for signs and symptoms of infection including increased erythema (redness), edema (swelling), warmth, exudate (drainage), malodor (bad smell/offensive odor) after cleansing. Report any concerns to medical provider. Date Initiated: 2/29/24. Review of the resident's progress notes, showed: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/29/24 at 7:43 A.M., Agency nurse note: Allegations made that this resident was involved in being harmed by another resident. Residents immediately separated, DON and Administrator made aware, and investigation has been started. Call placed to primary physician. This nurse assessed resident and observed ashes on left side of head. Cleaned area with soap and water. No open skin observed. Resident calm and cooperative. Denies pain; -2/29/24 at 9:00 A.M., DON note: Client assessed by this Registered Nurse (RN). Small area noted to right forehead, greyish in color, fluid filled blister, approximately 0.5 centimeters (cm) long by 0.5 cm wide by 0 cm deep. Client interviewed by this RN, Administrator and Social Services Director (SSD). Client asked if he/she felt safe and client stated, Yes, I do feel safe. No, it doesn't hurt.; -2/29/24 at 11:48 A.M., Wound Nurse (WN) note: Resident skin assessed with blister noted to right forehead hairline. No other areas noted; -2/29/24 at 11:50 A.M., WN note: Physician made aware of incident. Multiple attempts to notify family. Unable to leave message. No return call at this time; -2/29/24 at 11:57 A.M., WN note: Area noted approximately 0.5 cm by 0.5 cm rolled skin. Physician made aware with treatment order in place; -3/2/24 at 2:47 P.M., Nurse's note: Resident up in wheelchair, alert and able to make his/her needs known, Resident has a scab area top of his/her head, no redness/warmth noted. Resident denies any pain or discomfort. Safety maintained, call light in reach; -3/5/24 at 11:16 A.M., Social Services (SS) note: SSD spoke with resident regarding on how he/she was doing since the incident that he/she had with another resident. Resident states that he/she is doing fine, and that he/she never had an issue with the resident before. SSD will continue to monitor to see how resident is doing. Review of the resident's weekly skin check, dated 2/29/24, showed: -New non-pressure skin condition; -Blister to right forehead hair line. Review of the resident's physician order, dated 2/29/24 at 8:01 A.M., showed: -Order: cleanse area to right forehead with wound cleanser, apply Medihoney, apply border gauze dressing daily, every day shift for wound care. Review of Resident #4's progress notes, showed: -2/29/24 at 7:32 A.M., Behavior Note: Allegations made that this resident was involved in causing another resident harm. DON and Administrator made aware and investigation has been started. Call placed to primary physician and psychiatric physician. Residents were immediately separated by staff; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/29/24 at 8:11 A.M., Communication with Physician: Call placed to Primary Nurse Practitioner (PNP) for Veterans Affairs (VA) psychiatric department. PNP made aware of allegation against the resident and the resident was issued an immediate discharge related to the welfare and needs of the resident cannot be met in the facility. The safety of other individuals in the facility is endangered. The health of other individuals in the facility would otherwise be endangered. PNP for VA psychiatric department stated, I will call the ER at the VA and start looking for placement for the resident because he/she can't be doing things like that. Review of the facility's Follow-up Investigation Report, dated 3/5/24, showed: -Additional/Updated Information Related to the Reported Incident: --Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm: Resident #5 has a blister to right forehead hairline area; 0.5 cm by 0.5 cm; --Whether the allegation was reported to the resident representative, and if so, date/time: Calls were attempted to resident's contacts without success on the day of incident. Incident was communicated to family member face to face upon visit on 3/1/24; -Steps taken to investigate the allegation: --Summary of interviews with the alleged victim and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on incurred psychological harm and distress: Resident #5 stated he/she was going out the door to the designated smoking area and Resident #4 was coming in. Resident #4 became upset, yelling and telling him/her to move and placed his/her lit cigarette on Resident #5's head. Resident #5 appeared ok and voiced being ok. No visual signs of distress or fear; --Summary of interview(s} with witness(es), what the individual observed or knowledge of the alleged incident or injury: Residents #8, #9 and #10 were interviewed. None of the residents voiced the incident and made it appear the incident that occurred was unintentional; --Summary of interview(s) with the alleged perpetrator: Resident #4 voiced that he/she was trying to assist with moving Resident #5 from in front of the door. Resident #4 voiced his/her cigarette was in his/her mouth and it fell on resident. Resident #4 denies intentionally causing harm to Resident #5; --Summary of interview(s) with other residents who may have had contact with the alleged perpetrator: Several residents were interviewed to see if they knew Resident #4 and if they were fearful. Several stated they were; one stated that he/she is at times; and one stated that he/she wasn't scared of Resident #4, but didn't trust him/her; --Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides: Dietary aide was providing oversight at the time of incident and assisting another resident with smoking. Aide immediately intervened and separated residents; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator, if staff or a resident: Dietary aide was providing oversight at the time of incident and actually assisting a resident with smoking. Aide immediately intervened and separated; --Provide summary information from the investigation related to the incident, from the resident's clinical record, such as relevant portions of the Resident Assessment Instrument (RAI), the resident's care plan, nurses' notes, social services note, lab reports, x-ray reports, physician or other practitioner reports or reports from other disciplines that are related to the incident. If a resident to resident altercation occurred, provide any relevant details that may have caused the alleged perpetrator's behavior, such as habits, routines, medications, diagnosis, how long he/she may have lived at the building, or Brief Interview for Mental Status (BIMS, a brief screener of cognition) score: Resident #5- BIMS 15; diagnoses include CVA (stroke) with left non-dominant side and hypertension (high blood pressure). Resident #4- BIMS 15; diagnoses include heart failure, paranoid schizophrenia and panic disorder; --If available within the five business day timeframe, provide summary information of other documents obtained, such as hospital/medical progress notes, orders and discharge summaries, law enforcement reports, and death reports as applicable: Resident #4 was discharged to the VA hospital for psychiatric evaluation and appropriate placement; a discharge letter was issues due to Resident #4's care exceeds current capacity; -Conclusion: --Verified: The allegation was verified by evidence collected during the investigation; --Indicate if the allegation was verified by evidence collected during the investigation: Evident blistering to Resident #5's head; --Not Verified: The allegation was refuted by evidence collected during the investigation. Indicate and describe why the allegation was unable to be verified during the investigation: Resident #4 denies intentional harm; -Corrective Action(s) Taken: --Describe any action(s) taken as a result of the investigation or allegation: Education to staff regarding abuse, resident to resident altercation, and behavior intervention, 15-minute checks was initiated immediately after the incident, physician notified on both residents; --Describe the plan for oversight of implementation of corrective action, if the allegation is verified: Resident #4 is no longer at facility; --As a result of a verified finding of abuse, such as physical, sexual or mental abuse, identify counseling or other interventions planned and implemented to assist the resident: Continuous education, discuss safety with residents, and resident to resident altercations at next resident council, but as necessary prior; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--If systemic actions (e.g., changes to facility staffing patterns, changes in facility policies, training) were identified that require correction, identify the steps that have been taken to address the systems: Not applicable; --If the allegation was reported to law enforcement or another state agency, where applicable and if available, what is the status or provide conclusions of their investigation: Not applicable; -Submitted by: Administrator on 3/5/24. During an interview on 3/5/24 at 11:27 P.M., Resident #5 said Resident #4 intentionally put his/her cigarette out on Resident #5's forehead. Resident #4 did not drop his/her cigarette on his/her head. Resident #5 used his/her hand and pushed the cigarette onto his/her forehead and ground the cigarette out, while yelling at him/her. He/She really doesn't know why he/she did that. He/She did not do anything to provoke Resident #4. Resident #4 is loud and yells/cusses a lot but has never hurt him/her before. The burn blistered up and it hurt for a long time. The facility did not call the police, but he/she thinks they should have. He/She wanted to press charges. He/She feels much safer now that Resident #4 is no longer in the facility. During an interview on 3/5/24 at 12:20 P.M., Resident #8 said he/she was in the smoking area at the time of the incident. There was not a staff member in the smoking area at the time of the incident. Resident #5 was sitting in his/her wheelchair by the door smoking. Resident #4 told Resident #5 to move, started screaming at Resident #5, stood up, started kicking at Resident #5 and the door, pushed Resident #5's wheelchair, then walked up to Resident #5 and smashed his/her cigarette on Resident #5's forehead. It was intentional, he/she just did it to be mean. Resident #8 told Resident #4 that he/she could not do things like that and Resident #4 just rolled away into the dining room, ignoring Resident #8. Resident #5 was upset and said his/her head hurt where Resident #4 smashed the cigarette on his/her head. There was no reason for Resident #4 to do that. He/She could have gotten in the door around Resident #5. During an interview on 3/5/24 at 12:40 P.M., Resident #10 said he/she was in the smoking area and saw the entire incident. Resident #4 was finished smoking and wanted to go back inside. Resident #5 was sitting in his/her wheelchair by the door. He/She was not blocking the door. Resident #4 pushed Resident #5's wheelchair, yelled at him/her and then crushed his/her cigarette out on Resident #5's forehead. Resident #4 meant to put the cigarette out on Resident #4's forehead. Resident #5 did not drop his/her cigarette. Resident #5 intentionally bent forward with the cigarette in hand and crushed it out on Resident #5's forehead. Resident #10 went inside the building and told the Day Supervisor about the incident. The day supervisor went and checked on Resident #5. There was not a staff member in the smoking area at the time of the incident. During an interview on 3/5/24 at 1:03 P.M., Resident #9 said Resident #5 was near the door and Resident #4 wanted to go back inside. Resident #4 pushed Resident #5 in his/her wheelchair, kicked out at the door while yelling at Resident #5 and then put his/her cigarette out on Resident #5's forehead. It was intentional, he/she was mad. There was not a staff member in the smoking area at the time of the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/24 at 12:43 P.M. and 3:18 P.M., Dietary Aide (DA) B said he/she was in the smoking area at the time of the incident. He/She was sitting to the side, assisting another resident to smoke. His/her back was to the smoking area, he/she was looking at the wall because he/she had the resident looking out into the smoking area. DA B did not see the incident happen. He/She just heard the commotion and turned to see what was going on. The residents were separated immediately. He/she did not see the burn mark on Resident #5's forehead at the time. DA B informed the Day Supervisor about the incident. He/She has been working at the facility for 6 years. DA B believes he/she had some training on monitoring smoking residents when he/she started but has been monitoring smoking residents for a long time and knows what to do. He/She does not believe there is a list of responsibilities/expectations the facility expects staff to follow while monitoring smokers. DA B was assisting another resident that could not hold the cigarette for himself/herself. The other residents just need staff to light their cigarettes for them since they are not allowed to have lighters. During an interview on 3/6/24 at 1:20 P.M., the DON said Resident #4 burned Resident #5 on the head. He/She was told by the Day Supervisor. Resident #4 denied doing it intentionally. He/She does have shaking and he/she is remorseful. Resident #4 did have behaviors, but didn't feel it was actually intentional. The facility had to discharge him/her for other resident safety concerns. It does not look like a cigarette was put out on Resident #5's forehead, only like a small speck of fire fell on to him. DA B was in the smoking area when the incident occurred. The residents were separated. The DON believes staff who monitor the smoking area get training on what is expected of them while monitoring smoking residents. The expectations should be in the smoking policy. Staff are aware they should keep all residents in sight while smoking. Some residents need increased assistance with smoking. The monitor has to physically assist some residents with smoking while they are in the smoking area. There are no other staff to assist with monitoring other residents in the smoking area at these times. The DON expected staff to monitor all residents in the smoking area and who are smoking. It is not appropriate for the monitor to have their back to residents. MO00232518

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41061 Based on observation, interview and record review, the facility failed to ensure nurses completed and documented the weekly risk skin assessments and weekly wound assessments and failed to upload wound reports to resident's electronic medical record (EMR) in a timely manner. In addition, the facility failed to document when a new wound was found, who was contacted and what measures were put in place and also failed investigate a wound caused by trauma, and report and repair a broken wheelchair which caused a wound on a resident (Resident #1). The sample size was three. The census was 75. Review of the facility's skin program policy and procedure, undated, showed: -Purpose: The purpose of the skin program is to ensure that every resident's skin condition is observed/evaluated on admission and a comprehensive and interdisciplinary care plan is developed and maintained to treat actual and/or prevent potential skin problems; -Policy: All residents are observed/evaluated upon admission and as needed for actual and/or potential skin problems. All residents will receive an individualized preventative skin plan of care at the time of admission. All residents with skin problems will receive an active skin plan of care at admission. Skin Care team meetings will be held weekly to address all ulcers and any other pertinent skin problems; -The nurse assesses/evaluates all residents upon admission; -Director of Nursing (DON)/Designee to review all residents weekly with skin ulcers for condition of wound, treatment changes, and additional barriers to healing and will document weekly using the Wound-Weekly Observation Tool; -Each resident will be assessed/evaluated a minimum of weekly by the nurse using the Skin Observation Tool in the electronic medical record (EMR). 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/31/23, showed: -Cognitively intact; -No behaviors noted; -Impairment on both sides of upper and lower body; -Dependent on staff for bathing, lower body dressing, personal hygiene, toileting, and transfers; -Wheelchair for locomotion; -Always incontinent of bowel and bladder; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included heart failure, end stage kidney disease, viral hepatitis, diabetes mellitus, and schizophrenia (breakdown in relation between thought, emotion and behavior leading to faulty perception, inappropriate actions and feelings); -No skin conditions present. Review of the resident's weekly skin check, dated 1/6/24 at 1:57 P.M., showed: -There were no areas on the body diagram showing any skin issue sites or description; -Comments/Summary: The resident had areas/treatments in place; -There were no other weekly skin checks found in the resident's EMR for the month of January. Review of the resident's wound management team wound report, showed: -On 1/9/24, the resident refused service; -On 1/16/24, the resident was not seen due to hospitalization ; -There were no other reports provided by the facility . Review of the resident's EMR, showed: -There were no wound assessments by the facility for January; -There were no wound reports uploaded into the resident's EMR for January; -There were no progress notes from 1/1/24 through 1/18/24, showing the facility identified a wound on the resident's left lower leg. Review of the resident's Physician Order Sheets (POS), dated January 2024, showed: -An order, dated 1/9/2 and discontinued on 1/18/24, to cleanse skin tear on left buttocks and left lower leg with wound cleanser, Xeroform gauze (petrolatum based dressing), cover with a dry dressing every day and as needed wound care. Review of the resident's Treatment Administration Record (TAR), dated January 2024, showed: -An order, dated 1/9/24 through 1/18/24, to treat the resident's left buttock and left lower leg every day and as needed was refused by the resident on 1/12 and 1/15. The resident was hospitalized on [DATE]. Review of the resident's progress notes, showed: -A note, dated 1/15/24 at 8:45 P.M., the resident was transported to the hospital via ambulance; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An admission note, dated 1/19/24 at 9:12 P.M., showed the resident had a new skin issue located at his/her left posterior leg; Review of the resident's POS, dated January 2024, showed: -An order, dated 1/25/24 and discontinued on 2/1/24, to cleanse wound on left lower leg with wound cleanser, apply Xeroform and cover with dry dressing every day shift for wound care; -There was no order found for weekly skin assessments. Review of the resident's TAR, dated January 2024, showed: -An order, dated 1/25/24 through 2/1/24, treat the resident's left lower left was administered as ordered. Review of the resident's progress notes, showed: -On 1/28/24, at 2:03 P.M., the resident left the facility to the hospital via ambulance. Review of the resident's care plan, dated 2/1/24, showed: -Problem: Impairment to skin integrity on left posterior calf; -Interventions included: identify/document potential causative factors and eliminate/resolve where possible; Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of clinical admission note, dated 2/5/24 at 8:63 P.M., showed: -Skin note: The resident had an open area on his/her fourth toe on his/her right foot and an open area under his/her left leg. Review of the resident's skin only evaluation, dated 2/6/24 at 1:44 A.M. showed: -Skin note: The resident has an area on his/her buttock, an open area on his/her fourth toe on his/her right foot and an open area under his/her left leg; -There was no documentation found of wound assessments included for the areas identified. Review of the resident's wound management team progress notes, showed: -On 2/6/24, the resident had a trauma/injury wound of the left calf, greater than 20 days old, measuring 17.9 centimeter (cm) by 6.1 cm by 0.1 cm, with moderate purulent (foul smelling) exudate (drainage), with 20% slough (non-viable yellow, tan, gray, green or brown tissue) and 80% granulation (red, healthy tissue) tissue in the wound bed; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Blue Circle Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2939 Magazine Street Saint Louis, MO 63106	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/13/24, the resident's trauma/injury wound of the left calf, greater than 27 days old, measures 10.4 cm by 5.8 cm by 0.1 cm, with moderate serosanguinous (composed of serum and blood) exudate, with 20% necrotic (black, dead tissue), 10% slough, and 70% granulation tissue present in the wound bed. Review of the resident's EMR, showed no wound assessments by the facility for February and there were no wound reports uploaded into the resident's EMR for February, 2024. Review of the resident's POS, dated February 2024, showed: -An order, dated 2/8/24, to cleanse the wound on the resident's left lower calf with wound cleanser, apply gentamicin ointment (antibiotic), cover with calcium alginate with silver (highly absorbent dressing) cover with dry dressing daily; -There was no order found for weekly skin assessments. Review of the resident's TAR, dated February 2024, showed: -An order dated 2/8/24, to treat the resident's left lower leg was blank on 2/9 and 2/13/24, showing not administered. Review of the resident's progress notes, dated 12/1/23 through 2/15/24, showed there was no documentation when the facility first identified the resident's wound located on his/her left lower leg and there was no documentation found the facility identified the resident's wheelchair was missing the left leg pad located on the resident's left foot rest. During an interview on 2/16/24 at 10:59 A.M., the Wound Nurse said: -She was responsible for completing residents' wound treatments if she was working and the nurses were responsible for treatments in her absence; -Nurses were responsible for resident skin assessments on admission, weekly and on discharge; -Nurses were expected to notify the Primary Care Physician (PCP), the resident's responsible party (RP), initiate a new treatment and describe the wound in the progress notes when they find a new wound on a resident. They were also expected to alert her by putting a note in her mail box; -She was responsible for completing resident's weekly wound assessments. She would not put the assessments in the resident's individual EMR, only in the facility weekly wound report; -She only completed an individual wound assessment in the resident's EMR when she first identified a new wound on a resident; -The facility had an outside wound management team come in to assess and treat the resident once a week. They sent in their reports and the Wound Nurse used the wound assessments for her wound report. She did not update the resident's individual EMR with the wound reports or detailed progress notes. The wound management team sent in their report with all residents combined; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She was responsible for completing the facility weekly wound report; -She would notify the resident's PCP, RP, get new orders and include all details in a progress note when a resident had a change of condition. Observation on 2/15/24 at 1:08 P.M., showed the resident lay in bed, waiting for staff to assist him/her into his/her wheelchair to go out to an appointment. The wheelchair had foot rests for both feet. The left side was in disrepair. During an interview on 2/15/24 at 1:10 P.M., the resident said: -He/She needed a new wheelchair because there was no pad where his/her left calf rubbed against metal; -He/She got the wound from the wheelchair; -He/She could not remember how long ago it had happened; -His/Her left calf still hurt when he/she had to use his/her wheelchair, there was something digging into his/her leg and it hurt; -He/She told staff about the broken wheelchair. He/She could not remember whom he/she reported the broken wheelchair or when. During an interview on 2/15/24 at 1:18 P.M. and at 1:27 P.M., Licensed Practical Nurse (LPN) C said: -Observation of the resident's wheelchair showed there were two foot rests attached to the wheelchair. The right foot rest had a right lower leg pad attached to the bar. On the left foot rest bar, there was an exposed rectangular metal plate, with sharp edges, which had two metal screws sticking out approximately 3 cm. The screw heads were covered with a dark, sticky substance which he/she tried to rub off with a paper towel. The paper towel showed dark streaks of red; -LPN C confirmed the metal plate with the exposed screws were directly where the resident's left lower leg would rest against while he/she was in the wheelchair, and was most likely the source of the resident's wound; -The left foot rest was missing a leg pad which would have attached to the metal plate; -He/She was not sure how long the resident's wheelchair was in that condition; -He/She noted the resident's wheelchair was too small for him/her; -The screws would have rubbed against the resident's wound. making it worse, possibly infecting the wound; -The resident had the wound on his/her left lower leg for approximately a month and a half; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was not sure who was responsible to make sure residents' wheelchairs were in good repair; -The night shift had a wheelchair cleaning schedule and should have caught the resident's broken left foot rest and had it repaired; -Nurses were responsible for completing weekly skin assessments and documenting in the EMR under assessments; -If a nurse was unable to complete a skin assessment, the next shift should complete it. If a resident refuses assessment, nurses were expected to document in progress notes. During an interview on 2/15/24 at 1:41 P.M., the Wound Nurse said: -She was made aware of the resident's left lower leg wound on 1/25/24; -The resident reported he/she hit his/her left leg on his/her wheelchair; -She did not put a note in the progress note showing when she found out about the resident's left lower leg wound or that he/she reported it was caused by trauma from his/her wheelchair; -She did not write a note because she expected whom ever knew about the resident's left lower wound first to write the note. She did not know who discovered the resident's wound initially; -She did notice the resident's wheelchair was in disrepair, missing a left leg pad. She told the maintenance man, who was no longer on staff, verbally; -The exposed metal plate, with screws popped out, were right where the resident's left lower leg wound would rest against while in the wheelchair; -Continued use of the broken wheelchair could have exacerbated the condition of the wound, making it worse, possibly causing an infection; -She did not write a note showing the resident's wheelchair was in disrepair, what was wrong with it, who she told and when, so others could follow up to make sure the wheelchair was repaired, for the resident's safety. During an interview on 2/15/24 at 2:15 P.M., the Administrator said: -She expected staff to have knowledge of and follow facility policy and procedures; -She expected nurses to complete weekly skin assessments and document in the resident EMR; -She expected nurses to complete weekly wound assessments, with the Wound Nurse's oversight and document in the residents' EMR; -The Wound Nurse was expected to check daily to make sure skin and wound assessments were completed as ordered and if not, then she was responsible to reassign them to nurses or complete them herself; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She expected nurses to investigate how a trauma wound may have occurred, document findings in an incident report and in progress notes to follow up the progression of the wound. She also expected nurses to notify the PCP, RP, get new orders, list interventions that were put in place, and care plan if necessary; -Night shift nursing staff were expected to clean and inspect wheelchairs. If they found any issues, she expected staff to notify their nurse who would tell the Assistant Director of Nursing (ADON) or DON who could then address the issue; -She expected nurses to document in progress notes any issues with wheelchairs, who was notified, if the wheelchair needed repairs and how to follow up; -She expected the ADON or DON to notify the maintenance department or therapy department of any wheelchairs in disrepair so they could find parts or replace the wheelchair; -She expected nurses to follow up on any broken equipment, for resident safety; -She was not aware of the resident's broken wheelchair or that his/her left lower leg wound was caused by the missing leg pad on his/her wheelchair; -She expected the wound management wound reports to get uploaded into each resident's EMR on a weekly basis; -Nurses were responsible for weekly wound assessments, regardless if the resident was seen by a wound management team. The wound management team's wound assessment did not replace a nurses' weekly wound assessment; During an interview on 2/28/24 at 1:54 P.M., the Administrator said: -She expected each wound have an individual order so nurses can know where the treatment is for and to document progression of wound. It also helps track if treatment is provided; -When a new wound is found, she expected the nurse to document and describe wound, where it was located, notify the PCP, and add new orders in the progress notes. She also expected nurses to make the Wound Nurse aware; -She expected residents to have an order for the wound team to evaluate and treat wounds; -The facility skin policy should include weekly wound assessments are expected for every resident with a non-pressure wound; -She expected an order for weekly skin assessments and weekly wound assessments; -The Charge Nurse and/or the Wound Nurse are expected to add the orders to the resident's POS. Usually, the Wound Nurse gets the order for wound team as she will evaluate the new wound. Weekly skin and weekly assessment orders are usually put in by Charge Nurse, if not, then by the Wound Nurse. MO00230961

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34926 Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident #5) who was intentionally burned on the forehead with a cigarette by another resident (Resident #4). The census was 75. Review of the facility's Smoking Policy, revised on 8/1/22, showed: -Policy: Residents who smoke will be assessed for needed assistance upon admission, quarterly and with a significant change; -All residents are to be supervised while smoking; -Staff will light all smoking products and provide other assistance and protective devices as needed; -Residents are not allowed to supervise or assist other residents in smoking; -The failure of residents and visitors to comply with these rules places others at risk for injury. The facility may have to insist that resident and family find alternative placement if smoking and safety rules are not followed; -Violations of the smoking policy may result in revocation of smoking privileges. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/9/23, showed the resident: -Cognitively intact; -No behaviors; -Diagnoses included schizophrenia (a serious mental disorder in which people interpret reality abnormally) and anxiety disorder. Review of the resident's care plan, in use at the time of the incident, showed: -Focus: TOBACCO USE/SMOKING: Resident wishes to smoke/use tobacco products/vape while residing in the facility. Date Initiated: 11/24/23; -Goal: Resident will smoke/use tobacco safely in designated areas at designated times through next review. Date Initiated: 11/24/23. Resident will express understanding of and follow smoking/tobacco policies and storage of tobacco related items, through next review. Date Initiated: 11/24/23; -Interventions: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Educate resident/responsible party (RP) regarding center's smoking policy, designated smoking areas, and storage of smoking materials. Date Initiated: 11/24/23; --Monitor resident's safety during smoking. Report any concerns to charge nurse for further investigation. Date Initiated: 11/24/23; --Provide education as needed on safe smoking practices. Date Initiated: 11/24/23; --Monitor for violations of smoking policy. Report violations to Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON). Date Initiated: 11/24/23; -Focus: The resident is/has potential to be verbally aggressive related to Ineffective coping skills, poor impulse control. Involved in a Resident to Resident verbal altercation. Date Initiated: 02/24/24; -Goal: The resident will demonstrate effective coping skills through the review date. Date Initiated: 2/24/24; -Interventions: --Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 2/24/24; --Assess resident's coping skills and support system. Date Initiated: 2/24/24; --When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Date Initiated: 2/24/24. Review of the resident's Smoking and Safety form, dated 1/29/24, showed: -Smoking and Safety: --Supervision, designated smoking location, and smoking times are determined by facility policy. This evaluation will be utilized for the Resident's smoking care plan on admission and as indicated; --Does not display any of the following: limited or no range of motion (ROM) in arms or hands, insufficient fine motor skills needed to securely hold tobacco products, balance problems while sitting or standing, or Poor vision or blindness; --Does not display any of the following safety concerns: unable to light tobacco safely, unable to hold tobacco products safely, unable to extinguish tobacco or safely, or unable to use ashtray to extinguish tobacco; --No smoking safety notes; -Care Planning: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Smoking Care Planning: No focus, goal or interventions marked. Review of the resident's progress notes, showed: -1/03/24 at 4:42 P.M., Behavior Note: Resident continues to yell and scream at staff about medications and has been threatening to other residents. He/She is now stating that he/she knows this resident is a thief and attempted to jump on that resident. Resident's physician is here and resident has been harassing him/her for medications. Resident's physician agrees that resident does need psychiatric management. Police present in the facility for another resident when this resident began to yell out for no apparent reason and became belligerent in their presence. EMS arrived and was given a report of resident's behaviors; -1/18/24 at 2:30 P.M., Nurse's Note: Resident readmitted to facility; -2/02/24 at 6:33 A.M., Behavior Note: Resident was yelling and cursing to himself/herself in room, roommate was asleep. Resident now walking around facility no further behaviors noted; -2/06/24 at 9:40 A.M., Behavior Note: Resident in the hallway yelling and verbal aggression towards staff and other residents. He/She is refusing medications, using vulgar language (such as bitch sucking dick) in hallways. Not easily redirected. Pacing hallways. Call to psychiatry. Will follow up; -2/06/24 at 1:56 P.M., Communication with physician: Resident is having behaviors that are affecting other residents. He/She is yelling and cursing in the hallway. This writer reached out to the psych nurse practitioner (PNP) to let him/her know what the resident is doing. PNP recommends changing the resident's injection to every 14 days instead of every 21 days and he/she will be in soon to see the resident; -2/07/24 at 11:13 A.M., Behavior Note: Resident exhibiting negative behaviors. Resident in the hall using profanity as he/she is walking, Resident is extremely loud as well. This nurse asked resident to tone his/her voice down. Resident said, I can do what the fuck I want to do in here, call the police if you want to, I don't care. This nurse asked Resident if I can give him/her his/her routine injection, and resident responded yes. This nurse explained to resident that the PNP wanted the injection to start being given in his/her buttocks. Resident became very angry and said, fuck her and y'all, ain't nobody giving shit in my ass, fuck all y'all motherfuckers, this my body and I say where I want it to go, Y'all no good motherfuckers think you can do what you want to do to me. This nurse explained to the resident that I will give the injection where he/she allows me to give it. Resident said, I'll let you give it in my arm, but nowhere else, This nurse administered the injection to left deltoid with no problem. The resident's physician is here and made aware. Review of the resident's psychiatry note, dated 2/7/24, showed: -Initial psychiatric visit at the facility; -discharged from psychiatric ward on 1/16/24. On 1/3/24, resident was brought in by Emergency Medical Services (EMS) for stealing and fighting with other residents. Resident denied stealing, saying others were stealing from him, and he was in a verbal altercation; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interval history: Resident admits difficulty in adjusting to living in a facility. Staff reports that he/she can be very rude with staff; -Impression: schizophrenia, paranoid; -Plan: Have spoken with staff, who convey that the resident is behaviorally difficult to manage. Resident does admit that he/she does have a temper. Fluphenazine (an antipsychotic medication used to treat schizophrenia and psychotic symptoms such as hallucinations, delusions, and hostility) injections every two weeks. Review of the resident's progress notes, showed: -2/22/24 at 5:45 P.M., Nurse's Note: Upon Certified Nursing Assistant (CNA) entering the resident's room, a strong cigarette smoke smell in the room. CNA called for nurse. This nurse entered room with the strong smell of cigarette smoke. Resident denied smoking in his/her room despite the strong smell of cigarette smoke. Resident refusing to give this nurse his/her cigarettes and lighter, Resident provided education on the smoking policy. Resident verbalizes understanding; -2/24/24 at 5:08 A.M., Behavior Note: Verbal altercation between the resident and his/her roommate over TV being on and too loud. Resident #4 was yelling and cursing and pulling the resident's bed linen from bed. Staff intervened and diffused the situation. The residents were temporarily put in separate rooms until further notice. Assistant Director of Nursing (ADON) notified; -2/24/24 at 1:40 P.M., Behavior Note: Per the Charge Nurse, this client became upset that his/her roommate's television was loud. Client yelled at roommate but there was no physical contact. Skin assessed; no new skin issues observed. Client tugged at roommate's bottom of sheet but did not make contact with the roommate. Client placed on 15-minute observation checks for 24 hours and roommates separated immediately. Education given per Charge Nurse to notify staff for any and all concerns and to not touch belongings of others or yell at them. Client stated understanding; -2/27/24 at 4:27 P.M. Communication with Physician: This writer took a call from PNP and he/she had done a medication review on the resident. PNP wants to increase his/her buspirone (used to treat anxiety disorders) to 15 milligrams (mg) three times daily; -2/28/24 at 3:40 A.M., Behavior Note: Continues on observation for behaviors. Resident currently in room, appears to be calm and cooperative with staff. No behaviors observed at this time; -2/28/24 at 10:37 A.M., Behavior Note: Resident observed and overhead yelling on the phone with an unknown person. Resident being disruptive to the environment with his/her inappropriate vulgar language. Attempts to redirect resident to his/her room was unsuccessful. Shortly after attempt resident abruptly ended call and began to crawl to nurse station from front lobby area regarding needing medications. Resident's continued behavior was discussed amongst IDT. Psychiatry was contacted on yesterday regarding a medication review, with medication changes made. Resident was moved to a private room on 2/26/24 from temporary room as an intervention to eliminate roommate issues. Resident's 15 minute checks will be discontinued now after being placed on checks for verbal altercation with prior roommate on 2/24/24. No further issues with resident and that particular resident; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/29/24 at 7:32 A.M., Behavior Note: Allegations made that this resident was involved in causing another resident harm. DON and Administrator made aware and investigation has been started. Call placed to primary physician and psychiatric physician. Residents were immediately separated by staff; -2/29/24 at 8:11 A.M., Communication with Physician: Call placed to PNP for Veterans Affairs (VA) psychiatric department. PNP made aware of allegation against the resident and the resident was issued an immediate discharge related to the welfare and needs of the resident cannot be met in the facility. The safety of other individuals in the facility is endangered. The health of other individuals in the facility would otherwise be endangered. PNP for VA psychiatric department stated, I will call the ER at the VA and start looking for placement for the resident because (he/she) can't be doing things like that. Review of Resident #5's quarterly MDS, dated [DATE], showed the resident: -Was cognitively intact; -Had no behaviors; -Had functional impairment to bilateral (both) upper and lower extremities; -Required a wheelchair for mobility; -Had diagnoses that included stroke, hemiplegia (paralysis of one side of the body), and moderate protein-calorie malnutrition. Review of the resident's Care Plan, in use at the time of the incident, showed: -Focus: TOBACCO USE/SMOKING: Resident wishes to smoke/use tobacco products/vape while residing in the facility. Date Initiated: 11/08/23; -Goals: Resident will smoke/use tobacco safely in designated areas at designated times through next review. Date Initiated: 11/08/23. Resident will smoke/use tobacco safely through next review. Date Initiated: 11/08/23. Resident will express understanding of and follow smoking/tobacco policies and storage of tobacco related items, through next review. Date Initiated: 11/08/23; -Interventions: --Complete smoking assessment upon admission/when resident begins to smoke. Reassess as needed with change of condition that affects the ability to smoke. Date Initiated: 11/08/23; --Review smoking policy with resident/ upon admission and PRN (as needed). Date Initiated: 11/08/23; --Monitor resident's safety during smoking. Report any concerns to charge nurse for further investigation. Date Initiated: 11/08/23; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: Resident sustained a cigarette burn to forehead, not self-inflicted. Treatment initiated. Date Initiated: 11/08/23 and revised on: 2/29/24; -Goal: Risks associated with skin integrity will be minimized through review date. Date Initiated: 11/08/23; -Interventions: Complete treatment(s) per order. Monitor any areas of skin impairment for signs and symptoms of infection including increased erythema (redness), edema (swelling), warmth, exudate (drainage), malodor (bad smell/offensive odor) after cleansing. Report any concerns to medical provider. Date Initiated: 2/29/24. Review of the resident's February 2024 progress notes, showed: -2/29/24 at 7:43 A.M., Agency nurse note: Allegations made that this resident was involved in being harmed by another resident. Residents immediately separated, DON and Administrator made aware, and investigation has been started. Call placed to primary physician. This nurse assessed resident and observed ashes on left side of head. Cleaned area with soap and water. No open skin observed. Resident calm and cooperative. Denies pain; -2/29/24 at 9:00 A.M., DON note: Client assessed by this Registered Nurse (RN). Small area noted to right forehead, greyish in color, fluid filled blister, approximately 0.5 centimeters (cm) long by 0.5 cm wide by 0 cm deep. Client interviewed by this RN, Administrator and Social Services Director (SSD). Client asked if he/she felt safe and client stated,Yes, I do feel safe. No, it doesn't hurt.; -2/29/24 at 11:48 A.M., Wound Nurse (WN) note: Resident skin assessed with blister noted to right forehead hairline. No other areas noted; -2/29/24 at 11:50 A.M., WN note: Physician made aware of incident. Multiple attempts to notify family. Unable to leave message. No return call at this time; -2/29/24 at 11:57 A.M., WN note: Area noted approximately 0.5 cm by 0.5 cm rolled skin. Physician made aware with treatment order in place; -3/2/24 at 2:47 P.M., Nurse's note: Resident up in wheelchair, alert and able to make his/her needs known, Resident has a scab area top of his/her head, no redness/warmth noted. Resident denies any pain or discomfort. Safety maintained, call light in reach; -3/5/24 at 11:16 A.M., Social Services (SS) note: SSD spoke with resident regarding how he/she was doing since the incident that he/she had with another resident. Resident states that he/she is doing fine, and that he/she never had an issue with the resident before. SSD will continue to monitor to see how resident is doing. Review of the resident's weekly skin check, dated 2/29/24, showed: -New non-pressure skin condition; -Blister to right forehead hair line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Blue Circle Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2939 Magazine Street Saint Louis, MO 63106	

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's physician order, dated 2/29/24 at 8:01 A.M., showed: -Order: cleanse area to right forehead with wound cleanser, apply Medihoney (used for wound healing), apply border gauze dressing daily, every day shift for wound care. Review of the facility's Follow-up Investigation Report, dated 3/5/24, showed: -Additional/Updated Information Related to the Reported Incident: --Describe any additional outcomes to the resident(s), identifying/describing any physical and mental harm: Resident #5 has a blister to right forehead hairline area; 0.5 cm by 0.5 cm; --Whether the allegation was reported to the resident representative, and if so, date/time: Calls were attempted to resident's contacts without success on the day of incident. Incident was communicated to family member face to face upon visit on 3/1/24; -Steps taken to investigate the allegation: --Summary of interviews with the alleged victim and/or the victim's responsible party, if applicable. Indicate any visual cues from the resident of psychosocial distress and harm and the resident's perspective on incurred psychological harm and distress: Resident #5 stated he/she was going out the door to the designated smoking area and Resident #4 was coming in. Resident #4 became upset, yelling and telling him/her to move and placed his lit cigarette on Resident #5's head. Resident #5 appeared ok and voiced being ok. No visual signs of distress or fear; --Summary of interview(s} with witness(es), what the individual observed or knowledge of the alleged incident or injury: Residents #8, #9 and #10 were interviewed. None of the residents voiced the incident and made it appear the incident that occurred was unintentional; --Summary of interview(s) with the alleged perpetrator: Resident #4 voiced that he/she was trying to assist with moving Resident #5 from in front of the door. Resident #4 voiced his/her cigarette was in his/her mouth and it fell on resident. Resident #4 denies intentionally causing harm to Resident #5; --Summary of interview(s) with other residents who may have had contact with the alleged perpetrator: Several residents were interviewed to see if they knew Resident #4 and if they were fearful. Several stated they were; one stated that he/she is at times; and one stated that he/she wasn't scared of Resident #4, but didn't trust him/her; --Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides: Dietary aide was providing oversight at the time of incident and assisting another resident with smoking. Aide immediately intervened and separated residents; --Summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator, if staff or a resident: Dietary aide was providing oversight at the time of incident and actually assisting a resident with smoking. Aide immediately intervened and separated; (continued on next page)

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	265817	A. Building B. Wing	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Circle Rehab and Nursing	2939 Magazine Street Saint Louis, MO 63106

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Provide summary information from the investigation related to the incident, from the resident's clinical record, such as relevant portions of the Resident Assessment Instrument (RAI), the resident's care plan, nurses' notes, social services note, lab reports, x-ray reports, physician or other practitioner reports or reports from other disciplines that are related to the incident. If a resident to resident altercation occurred, provide any relevant details that may have caused the alleged perpetrator's behavior, such as habits, routines, medications, diagnosis, how long he/she may have lived at the building, or Brief Interview for Mental Status (BIMS, a brief screener of cognition) score: Resident #5- BIMS 15; diagnoses include CVA (stroke) with left non-dominant side and hypertension (high blood pressure). Resident #4- BIMS 15; diagnoses include heart failure, paranoid schizophrenia and panic disorder; --If available within the five business day timeframe, provide summary information of other documents obtained, such as hospital/medical progress notes, orders and discharge summaries, law enforcement reports, and death reports as applicable: Resident #4 was discharged to the VA hospital for psychiatric evaluation and appropriate placement; a discharge letter was issues due to Resident #4's care exceeds current capacity; -Conclusion: --Verified: The allegation was verified by evidence collected during the investigation; --Indicate if the allegation was verified by evidence collected during the investigation: Evident blistering to Resident #5's head; --Not Verified: The allegation was refuted by evidence collected during the investigation. Indicate and describe why the allegation was unable to be verified during the investigation: Resident #4 denies intentional harm; -Corrective Action(s) Taken: --Describe any action(s) taken as a result of the investigation or allegation: Education to staff regarding abuse, resident to resident altercation, and behavior intervention, 15-minute checks was initiated immediately after the incident, physician notified on both residents; --Describe the plan for oversight of implementation of corrective action, if the allegation is verified: Resident #4 is no longer at facility; --As a result of a verified finding of abuse, such as physical, sexual or mental abuse, identify counseling or other interventions planned and implemented to assist the resident: Continuous education, discuss safety with residents, and resident to resident altercations at next resident council, but as necessary prior; --If systemic actions (e.g., changes to facility staffing patterns, changes in facility policies, training) were identified that require correction, identify the steps that have been taken to address the systems: Not applicable; --If the allegation was reported to law enforcement or another state agency, where applicable and if available, what is the status or provide conclusions of their investigation: Not applicable; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Submitted by: Administrator on 3/5/24. During an interview on 3/5/24 at 11:27 P.M., Resident #5 said Resident #4 intentionally put his/her cigarette out on Resident #5's forehead. Resident #4 did not drop his/her cigarette on his/her head. Resident #5 used his/her hand and pushed the cigarette onto his/her forehead and ground the cigarette out, while yelling at him/her. He/She really doesn't know why he/she did that. He/She did not do anything to provoke Resident #4. Resident #4 is loud and yells/cusses a lot but has never hurt him/her before. The burn blistered up and it hurt for a long time. The resident feels much safer now that Resident #4 is no longer in the facility. During an interview on 3/5/24 at 12:20 P.M., Resident #8 said he/she was in the smoking area at the time of the incident. There was not a staff member in the smoking area at the time of the incident. Resident #5 was sitting in his/her wheelchair by the door smoking. Resident #4 told Resident #5 to move, started screaming at Resident #5, stood up, started kicking at Resident #5 and the door, pushed Resident #5's wheelchair, then walked up to Resident #5 and smashed his/her cigarette on Resident #5's forehead. It was intentional, he/she just did it to be mean. Resident #8 told Resident #4 that he/she could not do things like that and Resident #4 just rolled away into the dining room, ignoring Resident #8. Resident #5 was upset and said his/her head hurt where Resident #4 smashed the cigarette on his/her head. There was no reason for Resident #4 to do that. He/she could have gotten in the door around Resident #5. During an interview on 3/5/24 at 12:40 P.M., Resident #10 said that he/she was in the smoking area and saw the entire incident. Resident #4 was finished smoking and wanted to go back inside. Resident #5 was sitting in his/her wheelchair by the door. He/She was not blocking the door. Resident #4 pushed Resident #5's wheelchair, yelled at him/her and then crushed his/her cigarette out on Resident #5's forehead. Resident #4 meant to put the cigarette out on Resident #4's forehead. Resident #5 did not drop his/her cigarette. Resident #5 intentionally bent forward with the cigarette in hand and crushed it out on Resident #5's forehead. Resident #10 went inside the building and told the Day Supervisor about the incident. The Day Supervisor went and checked on Resident #5. There was not a staff member in the smoking area at the time of the incident. During an interview on 3/5/24 at 1:03 P.M., Resident #9 said Resident #5 was near the door and Resident #4 wanted to go back inside. Resident #4 pushed Resident #5 in his/her wheelchair, kicked out at the door while yelling at Resident #5 and then put his/her cigarette out on Resident #5's forehead. It was intentional, he/she was mad. There was not a staff member in the smoking area at the time of the incident. During an interview on 3/5/24 at 3:12 P.M., the Wound Nurse said it was all over when he/she got to the facility. He/She initiated 15-minute checks on Resident #5 until Resident #4 was sent out to the hospital. He/She assessed Resident #5 and he/she did not have a blister or fluid filled area, the skin was just rolled a little. He/She notified the resident's physician and got a new order for treatment to the site. During an interview on 3/6/24 at 12:29 P.M., Certified Medication Technician (CMT) M said he/she was not in the facility when the incident occurred. The incident happened on the night shift. The witness residents told him/her that Resident #4 put his/her cigarette out on Resident #5's forehead. Resident #5 had a blister on his/her forehead. It is just a scabbed area now. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/24 at 12:43 P.M. and 3:18 P.M., Dietary Aide (DA) B said he/she was in the smoking area at the time of the incident. He/She was sitting to the side, assisting another resident to smoke. His/her back was to the smoking area, he/she was looking at the wall because he/she had the resident looking out into the smoking area. DA B did not see the incident happen. He/she just heard the commotion and turned to see what was going on. The residents were separated immediately. DA B did not see the burn mark on Resident #5's forehead at the time. He/She informed the Day Supervisor about the incident. He/She has been working at the facility for 6 years. He/She believes he/she had some training on monitoring smoking residents when he/she started but has been monitoring smoking residents for a long time and knows what to do. DA B does not believe there is a list of responsibilities/expectations the facility expects staff to follow while monitoring smokers. He/She was assisting another resident that could not hold the cigarette for himself/herself. The other residents just need staff to light their cigarettes for them since they are not allowed to have lighters. During an interview on 3/6/24 at 1:20 P.M., the DON said Resident #4 burned Resident #5 on the head. He/She was told by the Day Supervisor. Resident #4 denied doing it intentionally. He/She does have shaking and he/she is remorseful. Resident #4 did have behaviors, but doesn't feel it was actually intentional. The facility had to discharge him/her for other resident safety concerns. It does not look like a cigarette was put out on Resident #5's forehead, only like a small speck of fire fell on to him. DA B was in the smoking area when the incident occurred. The residents were separated. He/She believes staff who monitor the smoking area get training on what is expected of them while monitoring smoking residents. The expectations should be in the smoking policy. Staff are aware they should keep all residents in sight while smoking. Some residents need increased assistance with smoking. The monitor has to physically assist some residents with smoking while they are in the smoking area. There are no other staff to assist with monitoring other residents in the smoking area at these times. The DON expected staff to monitor all residents in the smoking area and who are smoking. It is not appropriate for the monitor to have their back to residents. MO00232518