STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265892	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Louis Altenheim	5408 South Broadway Saint Louis, MO 63111

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a clean, comfortable, and homelike environment for residents when the facility failed to address a large water stain on the ceiling of one resident's room and bathroom (Resident #41). The facility also failed to ensure lights were in working order for one hallway on the 300 unit. The census was 47.1. Review of Resident #41's medical record, showed his/her diagnoses included arthritis, anxiety, depression and diabetes. Observation and interview on 10/7/25 at 11:10 A.M., showed the resident lay in bed. He/She said he/she has no concerns except for the underside of the soffit next to his/her television. There was a dark brown stain on the under part of the soffit that has a spider web type shape and extends approximately 6 inches long and 18 inches wide. The resident said he/she was sitting in bed when it happened and was told a shower overflowed upstairs. The resident told the facility about the stain. It has been a little bit since he/she reported it and he/she wants it fixed. The spot is a focus when he/she lays in bed and does not like having to look at it. Observation of the bathroom showed a dark stain around the light as well. The resident was not aware of that because he/she does not use that bathroom since he/she is bed bound. During an observation and interview on 10/9/25 at 10:10 A.M., the Maintenance Manager said he gets work orders from the mailbox on each floor or they can talk to him through his walkie talkie for more urgent issues. On the fourth floor, the sink overflowed and it ran down to the room below, to the resident's room. The Maintenance Manager said he fixed the drywall from the incident and just needs to sand and paint. The Maintenance Manager was shown the resident's room. He said he was not aware of this issue. During an interview on 10/10/25 at 10:15 A.M., the Administrator and Director of Nurses (DON) said the Maintenance Manager should have followed up with the resident yesterday and returned to the resident's room if he said he was going to take care of it. 2. Observation on 10/8/25 at 10:12 A.M.,10/9/25 at 6:24 A.M. and 10/10/25 at 9:43 A.M., showed the lights were turned off on the back hall of the 300 unit. There was no ceiling lighting in the hallway of rooms 306, 307, nursing room, and rooms 308 through 312. The hallway was very dark with a Hoyer lift (mechanical lift) against the wall in the hallway. The hall light in between the nurses' station and the dining room, showed one light was missing with dark burn stains on the light fixture. During an interview on 10/8/25 at 10:12 A.M., Registered Nurse (RN) H said maintenance was testing the light this morning. They planned to fix the light, but they shut off the lights on the other side of the hall. During an interview on 10/10/25 at 9:55 A.M., the Maintenance Manager said the light had a short in it and the lights on the back hall were from the same switch. There are no smaller lights, night lights or anything to keep the hall lit. During an interview on 10/10/25 at 10:14 A.M., the Administrator said she expected the 300 hallway to have light and items cleared from the hallway, such as the Hoyer lift.

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility staff failed to obtain treatment orders timely and thoroughly document a new skin issue for one resident (Resident # 34) found with an untreated wound. The sample was 12. The facility census was 47.Review of the facility's, Pressure Ulcer/Skin Breakdown- Clinical Protocol Policy, dated April 2018, showed:-The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction); for example, immobility, recent weight loss, and a history of pressure ulcer(s);-In addition, the nurse shall describe and document/report the following:a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates (drainage) or necrotic (dead) tissue;b. Pain assessment;c. Resident's mobility status;d. Current treatments, including support surfaces; ande. All active diagnoses.-The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions;-The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer;-The physician will help identify and define any complications related to pressure ulcers. Review of the Resident's #35 admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/18/25, showed:-Mildly cognitively intact;-Risk of pressure ulcers/injuries: none,-Unhealed wounds: None;-Other Ulcers, wounds or skin problems: None;-Diagnosis includes fracture of the sternum (rib cage/chest wall), lymphedema (swelling), and venous insufficiency (limited blood flow to the veins). Review of the resident's care plan, in use during the survey, showed:-Problem: The resident has the potential for pressure ulcer development related to decreased mobility;-Goal: The resident will have intact skin, free of redness, blisters or discoloration by/ through the review date;-Approach/Intervention: Follow facility policies/protocols for the prevention of skin breakdown. Monitor/document/report as needed (PRN) any changes in skin status, appearance, color, wound healing, signs and symptoms of infection, wound size, stage. Review of the resident's electronic physician order sheets (ePOS), showed:-An order for skin assessment weekly;-An order for physical therapy and occupational therapy to evaluate for relieving seat cushion;-No treatment order for the buttocks. The review of the resident's shower sheets, showed:-09/13/2025 no new skin concerns;-09/24/2025 no new skin concerns;-10/01/2025 no new skin concerns. Review of the resident's medication administration record (MAR) and treatment administration record (TAR), dated October 2025, showed no documentation of treatments to the buttocks. Review of the resident's progress notes, showed:-9/20/2025 at 04:36 P.M., Location buttocks generalized. Issue type: Moisture associated skin damage (MASD). Wound acquired in-house. Length centimeters (cm) 0.2, width 0.2 cm, Depth 0.1 cm;-10/2/2025 at 07:04 P.M., Location buttocks generalized. Issue type: MASD. Wound acquired in-house;-10/8/2025 at 05:34 P.M., Braden (assessment to determine risk of skin breakdown) scored 17 (mild risk). Friction and shearing are a potential problem. Moisture: Occasionally moist, Activity walks occasionally. Resident is slightly limited. During an interview, on 10/8/2025 at 12:42 P.M., the resident said his/her bottom hurt and staff provided him/her with a small packet to put cream on his/her buttock. The resident said his/her child purchased a bigger tube of the same cream provided by staff. His/Her family member showered him/her two days ago and saw a wound. This was the main reason for the larger tube of barrier cream they provided. During an interview, on 10/08/2025 at 1:36 P.M., the Director of Nursing (DON) said she was unaware of any wound(s) on the resident, or any documents suggested wound(s). Observation at this time, showed a purple/red area on the resident's buttocks. Inside the groove between the buttocks, an open area was visible. The area blead. The DON said the wound was a sacral wound. During an interview on 10/8/2025 at approximately 2:14 P.M., Licensed Practical Nurse (LPN) F said he/she worked the previous weekend, Friday through Sunday, and there were no wounds on the resident at that time. Observation at this time showed LPN F measured the wound as length of 0.8 cm (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by 0.3 cm, width by 0.1 cm. LPN F said there was no drainage except sanguineous (bleeding), he/she would get an order for Calmoseptine (over-the-counter barrier cream for moisture) and consult for wound management. LPN F said the last skin assessment was 10/2/25 and showed moisture damage. The resident's purple bottom is pressure. Sometimes the skin assessment shows up on the MAR, but that is not the main source to locate the information. During an interview, on 10/9/2025 at 7:07 A. M, the Nurse Practitioner (NP) said the shearing occurred within 1-2 weeks. The wound was acute (sudden)/chronic (prolonged) due to the bilateral purple buttocks and open wound on the sacral (tailbone) region. Full thickens (most of the skin layers are destroyed) 50% skin and 50% granulation (new tissue growth). The NP said this diagnosis is primary dermatitis (inflammation of the skin) secondary to pressure. Review of the resident's ePOS, showed an order dated 10/10/2025, clean the sacrum (buttocks area) with wound cleanser and apply A&D ointment and collagen dressing (medicated pad to excel in healing) and secured with boarder gauze daily. During an interview on 10/10/2025 at 10:46 A.M., the DON said he/she would expect staff to follow the policies and procedures of the facility. She was unaware of any wounds until Wednesday 10/8/2025 but said the nurses on the floor were informed. He/she would expect problems like wound(s) to be brought to the attention of the DON to discuss addressing them in timely manner.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance to prevent accidents when staff failed to follow facility policy regarding resident alcohol storage. One resident had several bottles of drinking alcohol, four mini wine bottles and a 16 ounce (oz) open beer in his/her mini fridge (Resident #25). The census was 47. The sample was 12.Review of the facilities Alcoholic Beverages Policy revised February 2023, showed purpose: This procedure is to establish uniform guidelines concerning the administration of alcoholic beverages.-A physician's order must be received before any alcoholic beverages may be administered to a resident;-Should such an order be received, the nurse supervisor receiving the order must contact the pharmacist to determine if any of the residents' current medications would interact with alcohol. Should there be a medication that would interact with alcohol the nurse supervisor must inform the physician of such medication;-Alcoholic beverages must be paid for by the resident, his or her family, and/or the resident's representative (sponsor);-The Nurse Supervisor receiving the alcoholic beverage must label the bottle;-The label must contain:1. The resident name and room number;2. The exact dosage to be administered;3. The time(s) each dose is to be administered;4. The name of the physician;-Alcoholic beverages must be treated as medication and stored in the medicine room;-Should you have any doubt concerning the administration of the beverage to the resident, contact the Director of Nursing Services (DON). Review of Resident #25's quarterly change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/08/2025, showed:-Mildly impaired cognition;-Diagnoses included Parkinson's disease (neurological decline effecting one's ability to walk), depressive disorder, anxiety, and protein-calorie malnutrition. Review of Resident #25's care plan, in use at the time of the survey, showed:-Focus: 03/08/2023, have experienced unusual or especially frightening events. Used to be an alcoholic and had suicidal ideation in the past. No longer uses alcohol or have suicidal ideations:--Goal: I will not experience an adverse effect from an unusual or especially frighting event that he/she experience in life;--Intervention: Notify if feeling numb or detached from people, activities or surroundings because of the unusual or especially frightening, horrible, or traumatic event experienced, so that they may help at this moment;-Focus: Antidepressant medication Mirtazapine related to depression;--Goal: will be free from discomfort or adverse reactions related to antidepressant therapy through the review date;--Interventions include: administering antidepressants per physician's order and monitoring the signs and symptoms; monitoring/documenting/ reporting as needed (PRN) adverse reach actions to antidepressant therapy like changes in personability /mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities daily living (ADLs), loss weight, rigid muscles, etc.;-Focus: Has depression and has had a difficult time accepting current diagnosis of Parkinson's disease and living in a nursing home facility. He/she has been noted for making false accusations about other residents and staff;--Goal: Will have his/her risk of distress because of symptoms of depression, anxiety, or sad mood minimized;--Intervention: Administer medications per physician's order, have the resident attend activities of interest, refer to psych services as needed. Review of the resident's electric Physicians Order Sheet (ePOS), showed an order dated on 8/12/25 at 10:44 A.M., resident is allowed to consume 1-2 alcoholic beverages as tolerated daily. On 9/30/25, the order was discontinued by the medical provider reason: the attending physician did not approve; the strike out date was 10/8/25. Review of the resident's nursing progress notes, showed:-On 8/7/25 at 4:45 P.M., the resident has two small bottles of wine in the fridge in his/her room. The resident said that his/her sibling bought them for the resident. This nurse notified the physician and asked if he/she could have an alcohol order;-On 8/7/25 at 8:03 P.M., the nurse reached out to Power of Attorney (POA) to notify him/her of the wine found in the resident's room. POA did not respond;-On 8/12/25 at 10:44 A.M., the medical provider ordered 1-2 alcoholic beverages daily as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident 25's room on 10/07/25 at 11:38 A.M., showed inside the mini refrigerator 3 Sutter Home wine bottles and a 16 ounces (oz) open beer can. A small Sutter Home bottle of alcohol sat on the nightstand by the window. During an interview on 10/07/25 at 1:25 P.M., the resident said he/she drank at the direction of the owner of the facility. His/Her sibling purchased the alcohol. His/Her neurologist is aware of the use of alcohol. He/She had drunk the open beer in the fridge. The resident declined to answer any other questions. During an observation of the resident's room on 10/08/25 at 8:36 A.M., showed one bottle of Sutter Home wine on the nightstand. The resident's sibling was in the room and said the neurologist wrote a letter that implied the consumption of alcohol was fine. The sibling said there is no history of substance abuse and is unsure how this was entered into his/her care plan. He/She purchased the alcohol for the resident and was unaware of any policies from the facility that pertained to the use and or storage of alcohol. Observation of the resident's room on 10/8/25 at 9:30 A.M., showed 3 Sutter Home wine bottles and a 16 oz can of beer in the refrigerator. An additional bottle of wine sat on the nightstand next to the window. During an interview on 10/8/25 at 9:45 A.M., with DON and Administrator, they said residents who have alcohol orders also have a care plan for it. The DON said residents who are allowed to drink alcohol also have an order to withhold certain medications if needed. The Administer said he/she would rely on the medical provider when it comes to residents who indulge in alcohol with an active diagnosis of depression. The DON said it would depend on how much the resident consumes. Observation of the resident's room on 10/9/25 at 7:00 A.M., showed 1 Sutter Home wine on the nightstand with the resident's name and date. Review of the resident's medical record, showed:-A progress note dated 10/8/25 at 10:27 A.M., Spoke with POA regarding storage of the alcoholic beverages. Drink will be stored in the medication storage room until requested by the resident. The resident agrees with keeping the drinks in the medication storage room. The resident currently has two small bottles of Sutter Home Wine.-An order dated 10/09/25 at 9:12 A.M., Neurologist wrote; I am okay with Resident #25 having an occasional glass of wine with dinner. Continue medications as prescribed. Do not hold carbidopa-levodopa (Parkison medication). During an observation of the resident's room on 10/10/25 at 8:20 A.M., showed one bottle of Sutter Home wine on the nightstand the seal broken, and a small portion was gone. During an interview on 10/10/25 at 8:28 A.M., Licensed Practical Nurse (LPN) J said the resident kept asking for alcohol and the facility called the sister, who obtained an order for alcohol. The medical provider gave a verbal order via phone. LPN J was unaware of the order being canceled by the medical provider. The Social Worker (SW) said he/she was unaware of any residents who were allowed to drink in the facility. It would be a concern if a resident had a history of alcoholism and was allowed to drink. The social worker would expect more education for the resident and care planning. During an interview on 10/10/25 at 9:16 A.M., the medical provider said he/she never ordered or authorized a script to consume alcohol. He/She was aware their neurologist wrote a letter indicating the resident may drink occasionally. He/She would not interfere with any orders or medications prescribed by the neurologist. The medical provider said, from his/her understanding, the resident does not have a substance abuse problem with alcohol. He/She was made aware the resident only takes sips of alcohol and this would not have an negative effects on antidepressants, or antipsychotic medications. During an interview on 10/10/2025 at 10:46 A.M., the Administrator and DON said alcohol should not be in a resident's room. The administrator said he/she would want clarification of the care plan that said, I used to be an alcoholic.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure two residents' personal refrigerators had routine temperature tracking (Residents #1 and #30). The facility also failed to ensure the kitchen ceiling above the food preparation station was free from dust accumulation and failed to ensure the walk- in freezer was free from ice buildup. The sample was 12. The census was 47. Review of the facility's sanitation policy, revised 11/22, showed:-Policy statement: the food service area is maintained in a clean and sanitary manner;-Policy implementation: all kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/4/25, showed:-Cognitively intact;-Diagnoses included chronic obstructive pulmonary disease (COPD), muscle weakness, major depressive disorder and anxiety disorder. Observation on 10/7/25 at 11:14 A.M. and 10/8/25 at 9:41 A.M., showed the resident had a small refrigerator in the room. The refrigerator contained an undated container of soup, two opened containers of baking soda, various pieces of candy and a jar of salsa. A temperature log posted on the outside of the refrigerator was dated for the year of 2022. 2. Review of Resident #30's medical record, showed his/her diagnoses included congestive heart failure, dementia, diabetes, and hemiplegia (paralysis or weakness on one side) and hemiparesis (one sided muscle weakness) following cerebral infarction affecting right dominant side. Observation and interview on 10/8/25 at 2:19 P.M., showed the resident had a small refrigerator in the room. The resident's family member said he/she takes care of everything purchased in the refrigerator. The resident's refrigerator showed four nutritional shakes, orange juice, tea and chocolate pudding. There was no temperature log. 3. During an interview on 10/10/25 at 9:52 A.M., Licensed Practical Nurse (LPN) B said housekeeping is responsible for maintaining temperature logs for the residents' personal refrigerators. During an interview on 10/10/25 at 10:01 A.M., Housekeeper R said housekeepers were responsible for maintaining resident refrigerator temperature logs a long time ago but now maintenance is responsible. During an interview on 10/10/25 at 10:16 A.M., the Administrator said housekeeping is responsible for ensuring residents' personal refrigerators are routinely checked. She expected housekeepers to check refrigerator temperatures monthly. 4. Observation on 10/7/25, of the kitchen, showed:-At 10:47 A.M., two light fixtures and four tiles surrounding the light fixtures had dust accumulation. The dust accumulation was directly above the steam table section of the food preparation station;-At 10:50 A.M., the walk-in freezer had thick ice surrounding the underneath of the door frame. The inside of the walk-in freezer had a large ice chunk in the center of the floor with food debris on top of it. The ice buildup was approximately 3 inches in height. Observation on 10/8/25, of the kitchen, showed:-At 10:07 A.M., two light fixtures and four tiles surrounding the light fixtures had dust accumulation. The dust accumulation was directly above the steam table section of the food preparation station;-At 10:11 A.M., the walk-in freezer had thick ice surrounding the underneath of the door frame. The inside of the walk-in freezer had a large ice chunk in the center of the floor with food debris on top of it. The ice buildup was approximately 3 inches in height. Observation on 10/9/25 at 9:02 A.M., of the kitchen, showed two light fixtures and four tiles surrounding the light fixtures had dust accumulation. The dust accumulation was directly above the steam table section of the food preparation station. During an interview on 10/10/25 at 8:43 A.M., Dietary Aide S said maintenance is responsible for cleaning the ceilings in the kitchen. He/She said the ceilings should be clean to avoid contaminating the food. He/She said the Dietary Director or maintenance is responsible for cleaning ice buildup in the walk-in freezer. During an interview on 10/10/25 at 8:48 A.M., the Dietary Director (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said he expected the ceiling in the kitchen to be free from dust accumulation. He expected the walk-in freezer to be free from ice buildup. Maintenance is responsible for cleaning the ceiling. All dietary staff can clean ice buildup in the walk-in freezer. During an interview on 10/10/25 at 10:14 A.M., the Administrator said she expected the ceiling in the kitchen to be free from dust accumulation. She expected the walk-in freezer to be free from ice buildup.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review the facility failed to provide resident(s) the right to be informed and make choices about their care, when staff failed to inform a resident with dementia of the care to be provided and stop providing care when he/she yelled stop. Staff continued to provide care and mimicked or repeated residents' words the resident said during this time (Resident #35). The sample was 12. The census was 47. Review of the facility's Resident's Right Policy, dated February 2021, showed employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to:-A dignified existence;-Be treated with respect, kindness, and dignity;-Be supported by the facility in exercising his or her rights. Review of the facility's orientation and in-service training programs showed residents' rights training conducted quarterly to assist staff in understanding the residents' rights. Review of Resident #35's quarterly change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/17/25, showed:-Dementia (forgetfulness, memory impaired);-Hospice care;-Physical assistance for eating;-Physical dependence for hygiene, eating, transfers and daily care;-Diagnoses included Alzheimer's Disease, anxiety and mood disorder. Review of the resident's care plan, in use during the survey, showed:-Focus: Impaired cognitive functions/dementia;--Goal: Needs will be met through the review date as evidenced by no non-verbal signs and symptoms;--Interventions: Cue, reorient and supervise as needed, Communicate with the resident, family and caregivers regarding resident capabilities and needs;-Focus: Has actual/potential for a combination of problems related to dementia, anxiety and depression;--Goal: The resident will maintain their current level of communication function through the review date;--Interventions: Anticipate and meet needs; discuss with the resident and family concerns or feelings regarding communication difficulties; Monitor for decline in cognitive status, activities in daily living (ADLs), report to the nurse changes in ability to communicate, possible factors which cause/make things worse/make any communication problems better, any communication problems. During an observation and interview on 10/08/25 at 09:18 A.M., showed (Certified Nursing Assistant) CNA A and CNA C assisted the resident into bed by using a gait belt. CNA B left the room after the resident was safely in bed. CNA A removed the resident's pants without first explaining to the resident the care to be provided. The resident said, Stop, please! The resident then grabbed the CNA's hands. CNA A continued to provide personal care. He/She wiped the resident's perineal area (the surface area between the thighs, extending from the pubic bone to the tail bone) and rolled the resident. The resident said, Stop, stop, it's too cold. Get out of here before I call the police. CNA A said call the police while CNA A continued providing care. The resident repeated stop. The resident said, Don't touch me. Don't touch me. CNA A continued to provide care and put cream on the resident's buttocks, then applied a new brief. The resident said don't touch, don't touch. CNA A said, I am almost done. CNA A rolled the resident to the right and then left side to fasten the brief. CNA A never stopped to explain the procedure to the resident. During an interview on 10/08/25 at 09:452 A.M., CNA A said the resident is always this vocal with care. He/She has cared for the resident for about 1 year now. During an interview on 10/10/25 at 10:46 A.M., the Director of Nursing (DON) and the Administrator said they would expect staff members to follow facility policy and procedures while care is provided to residents. They would expect staff to stop performing a specific task if a resident requested them to stop. The DON said by continuing with the task, it is violating the residents' rights. The Administrator said she would never expect staff to mimic (imitate) residents. Both the DON and the Administrator said the resident's care plan should specify how to handle residents' refusals during cares.

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	265892	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Louis Altenheim	5408 South Broadway Saint Louis, MO 63111

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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. Based on observation, interview and record review, the facility failed to ensure one resident was free from abuse when a Certified Nursing Assistant (CNA) hit a resident on the arm (Resident #4). The sample was 12. The census was 47. Review of the facility's abuse/neglect policy, revised 9/2022, showed:-Policy statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported;-Policy implementation: If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/27/25, showed:-Severe cognitive impairment;-Diagnoses included dementia and anxiety disorder;-Physical behavioral symptoms directed toward others occurred four to six days, but less than daily;-Rejection of care behavior occurred one to three days. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: resident has dementia and is not always able to voice his/her needs/wants to staff. There are times when his/her needs have to be anticipated;-Goal: resident will have his/her needs/wants met through the next review;-Intervention: anticipate needs if resident is unable to make his/her needs/wants known. Make eye contact when talking to resident. Provide resident with instruction on completing his/her ADL tasks. Give him/her one task at a time;-Care plan failed to identify the resident's behavioral symptoms and rejection of care. Observation on 10/8/25 at approximately 12:29 P.M., showed CNA A pushed the resident, who was seated in his/her wheelchair, into the lobby area. The resident was seated in his/her wheelchair, facing the dining room. The resident wore one grip sock on the right foot. CNA A walked around the wheelchair and stood in front of the resident. CNA A bent over, grabbed the resident's left pant leg, and raised the resident's leg up by the pant material to put a sock on the resident's foot. The resident started to flail his/her arms. CNA A used his/her right hand to slap the resident on his/her left forearm. A slight audible nose was heard of CNA A's hand hitting the resident's arm, which was covered by his/her long sleeve. The resident had a distressed and scared facial expression and began to use his/her feet to ambulate in the wheelchair, however, the wheelchair was locked. At 12:30 P.M., the surveyor reported to Licensed Practical Nurse (LPN) B CNA A slapped the resident. LPN B immediately intervened. LPN B separated CNA A from the resident. LPN B walked with CNA A down the hallway and called for assistance. CNA A was escorted off the hallway by the Director of Nursing (DON). During an interview on 10/8/25 at 2:01 P.M., LPN B said he/she was seated at his/her desk approximately 8 feet from where the resident and staff were positioned. He/She said he/she saw CNA A attempting to help the resident with his/her grip sock through his/her peripheral vision but did not witness or hear the slap. He/She expected staff to step away if the resident is getting agitated and re-approach at a different time. Review of the facility's investigation, dated 10/10/25, showed:-During a phone interview with the Administrator on 10/9/25, CNA A stated that the resident had been digging his/her nails into his/her arm while he/she was attempting to place grip socks on the resident. CNA A explained that this behavior was not unusual for the resident. He/She reported that he/she pulled his/her arm back to release the resident's nails and emphasized that he/she did not, and would never, slap the resident. CNA A stated that he/she cares for the resident frequently and would never harm him/her in any way. He/She further noted that the resident frequently flails his/her arms and may grab onto nearby objects or individuals but again reiterated that he/she did not slap the resident;-The resident had a full body assessment completed with no injuries. The resident is not showing any signs of fearfulness, tearfulness, or mental anguish. During an interview on 10/10/25 at 10:20 A.M., the DON (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Administrator said they expected all residents to be free from abuse. Slapping a resident is not appropriate. They expected staff to step away and reapproach residents at a different time if the resident is combative. They said the resident has a history of being combative during care. 2638053

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure the resident's Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff) accurately reflected the resident's status of having a life expectancy of less than 6 moths when they received hospice services (a service provided when a resident has a condition indicating a life expectancy of less than 6 months as certified by the hospice physician) for one of two residents investigated for hospice services (Resident #20). The census was 47. Review of Resident #20's medical record, showed:-Diagnoses included Alzheimer's Disease, diabetes, dementia, and major depressive disorder.-A Hospice Comprehensive assessment showed a hospice start of care date of 7/29/24 and current benefit dates 7/24/25-9/21/25.-The current certification of terminal illness dated 9/22/25-11/20/25. Review of the resident's care plan, revised on 8/21/24, showed:-Focus: Resident is receiving hospice services with the admitting diagnosis of late onset Alzheimer's disease;-Goals: Resident's comfort will be maintained through the next review date;-Interventions: Work cooperatively with hospice staff to ensure resident's spiritual, emotional, intellectual, physical, and social needs are met. Provide end of life care and ensure residents end of life wishes are maintained. Review resident's living will and ensure it is followed, involve family in discussion. Review of the resident's annual MDS, dated [DATE], showed:-Special services received while a resident: Hospice Care marked;-Does the resident have a condition or chronic disease that may result in life expectancy less than six months: No.During an interview on 10/10/25 at 10:05 A.M., the MDS coordinator said he/she has been at the facility since January but just started in the MDS role. The MDS should be coded accurately. The 6 months or less prognosis should not be marked on the MDS unless there is documentation from the physician. During an interview on 10/10/25 at approximately 10:15 A.M., with the Administrator and the Director of Nursing (DON), the Administrator said she would have expected the resident's MDS to have been coded accurately and to accurately reflect the resident's status. The resident's MDS should have reflected he/she had a prognosis for a life expectancy of less than six months. The DON said she signs off on the MDS assessment and should have caught that error before it was submitted. During an interview on 10/10/25 at approximately 10:25 A.M., the MDS coordinator said he/she talked to the MDS consultant and the DON and said the six months or less to live should be marked on the MDS if the resident is on hospice.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) care needs were met for a dependent resident. The facility failed to ensure the resident received assistance in the dining room during meals and failed to ensure the resident's hands and nails were cleaned (Resident #4). The sample was 14. The census was 47. Review of the facility's ADL policy, revised 3/2018, showed:-Policy Statement: residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out ADL independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene;-Policy implementation: appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (meals and snacks); and, communication (speech, language, and any functional communication systems). 1. Review of resident #4's quarterly Minimum Data Set (MDS), A federally mandated assessment instrument completed by facility staff, dated 2/24/25, showed:-Severe cognitive impairment;-Diagnoses included dementia and anxiety disorder. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: resident has dementia and requires staff to assist him/her with ADL tasks;-Goal: resident will have his/her risk of decline in his/her ADL tasks through the next review date;-Interventions: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Provide finger foods when the resident has difficulty using utensils. The resident is able to feed himself/herself with assist and cueing. Provide assist when needed. Observations on 10/8/25, of the resident, showed:-At 8:44 A.M., the resident sat in his/her wheelchair at the dining room table, eating breakfast. The resident's nails were long and jagged with dark substance under them. The resident was eating scrambled eggs with his/her hands;-At 8:47 A.M., an unknown staff took the resident's breakfast tray from the resident before the resident was finished eating. Observation on 10/9/25 at 6:06 A.M., showed the resident sat in his/her wheelchair in the dining room. The resident's nails were long with dark matter underneath. The resident's hair appeared oily and unkempt. Observation on 10/10/25, of the resident during breakfast, showed:-At 7:34 A.M., the resident sat in his/her wheelchair at a table in the dining room. The resident's hands were dirty and sticky. The resident's nails were jagged and had dark matter underneath. A sweat odor was emitting from the resident. The resident's hair appeared oily;-At 8:17 A.M., the resident had been served his/her breakfast tray. He/She was sleeping with a piece of toast in his/her hand;-At 8:21 A.M., the resident woke up and started to eat his/her bacon;-At 8:25 A.M., the resident picked up the sock that was on his/her wheelchair seat and brought it up to his/her mouth and attempted to take a bite. He/She then placed the sock on top of his/her plate;-At 8:26 A.M., the resident picked up his/her meal ticket off his/her tray and attempted to take a bite of it;-At 8:32 A.M., the resident picked up a fork and started to eat his/her oatmeal. The oatmeal fell into the resident's lap from the fork. The resident lifted the oatmeal with his/her hands to eat. -At 8:39 A.M., the resident started to eat his/her oatmeal with his/her hands. He/She then continued to eat his/her scrambled eggs with his/her hands. During an interview on 10/10/25 at 9:25 A.M., Licensed Practical Nurse (LPN) G said nursing staff are to ensure residents' hands are washed after each meal. He/She would expect staff to assist residents during mealtimes if they are observed to be eating objects and not food. He/She said it is common for Resident #4 to eat with his/her hands. During an interview on 10/10/25 at 10:18 A.M., the Director of Nursing (DON) and Administrator said they would expect staff to assist residents in the dining room when needed. They would expect Resident #4 to have more staff oversight in the dining room to ensure the resident is only eating food. They would expect the resident to have a physician's order for finger foods if the resident is care planned for finger foods. They would expect nursing staff to ensure resident's hands are clean after meals.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow acceptable infection control standards while providing perineal care for one resident (Resident #30). The sample was 12. The census was 47.Review of the facility's Perineal Care Policy, revised February 2018, showed:-Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.-Preparation:--Review the resident's care plan to assess for any special needs of the resident.--Assemble the equipment and supplies as needed.-Equipment and Supplies-The following equipment and supplies will be necessary when performing this procedure:--Wash basin;--Towels;--Washcloth;--Soap (or other authorized cleansing agent); and--Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).-Steps in the Procedure:--Place the equipment on the bedside stand. Arrange the supplies so they can be easily reached;--Wash and dry your hands thoroughly;--Fill the wash basin one-half (1/2) full of warm water. Place the wash basin on the bedside stand within easy reach;--Fold the bedspread or blanket toward the foot of the bed;--Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet;--Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident's body;--Put on gloves;--Ask the resident to bend his or her knees and put his or her feet flat on the mattress. Assist as necessary.-For a female or male resident:--Wet washcloth and apply soap or skin cleansing agent;--Wash perineal area, wiping from front to back;--Continue to wash the perineum moving from inside outward to the thighs. Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth;--Gently dry perineum;--Ask the resident to turn on his/her side with his/her top leg slightly bent, if able;--Rinse wash cloth and apply soap or skin cleansing agent;--Wash the rectal area thoroughly, wiping from the base of the front genital area towards extending over the buttocks;--Rinse and dry thoroughly. Review of Resident #30's medical record, showed his/her diagnoses included diabetes, heart failure, dementia, hemiplegia and hemiparesis on right side following stroke (weakness affecting one side of the body) and peripheral vascular disease (a systemic disorder that involves the narrowing of peripheral blood vessels). Review of the resident's care plan, revised on 2/18/25, showed:-Focus: Resident is unable to stand and requires a Hoyer lift (mechanical lift) for transfers. He/She is dependent upon staff for all activities of daily living (ADL) tasks such as dressing, bathing, peri-hygiene, personal hygiene, and bed mobility. He/She is able to feed himself/herself with set up assist;-Goal: Resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date;-Interventions: Toilet hygiene provided dependent assist with 1 with peri care related to incontinent of bowel and bladder. Observation on 10/8/25 at 12:50 P.M., showed Certified Nursing Assistant (CNA) L and CNA J entered the resident's room. The resident lay in bed. CNA J and CNA L washed their hands and donned gloves. CNA J washed the resident's face, removed his/her gloves and donned a new pair without performing hand hygiene. CNA J removed the resident's gown, washed the resident's chest, removed his/her gloves and donned new gloves without performing hand hygiene. CNA J used wipes to cleanse the resident's groin area. CNA J removed his/her gloves and donned new gloves without performing hand hygiene. CNA J cleaned the resident's genital area from front to back and rolled the resident to his/her left side. CNA J removed his/her gloves and donned new gloves without performing hand hygiene. CNA J washed the resident's back then removed his/her gloves and donned new gloves without performing hand hygiene. CNA J then wiped the resident's buttock area toward the genital area. Twice, CNA J wiped from back to front. CNA J removed his/her gloves and donned new gloves without performing hand hygiene. During an interview on 10/10/25 at 9:18 A.M., Licensed Practical Nurse (LPN) Q said nursing staff should wash their hands when they enter a resident's room and at the end of the process. Their gloves should be changed and hand hygiene or hand washing should be done when they go from clean to dirty. Hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene should be completed because of the risk of contamination and for infection control. Females should be wiped front to back due to risk of bacteria or yeast infection. During an interview on 10/10/25 at 9:45 A.M., CNA L said hand hygiene should be completed before and after care and in-between glove changes. When cleaning a female resident, staff should go from the front to back when wiping the resident's genital area. When wiping the buttock area, wipe from the genital area to the buttock area. During an interview on 10/10/25 at 10:15 A.M., the Administrator and Director of Nursing (DON) said hand hygiene should be performed prior to perineal care, during care, and definitely after providing care. They should keep hand sanitizer to use between glove changes. If gloves are soiled, then wash hands in-between glove changes. Gloves should be changed when going from a dirty area to a clean one with hand hygiene performed in-between. When providing care for a female resident, the resident should be wiped from front to back or from genital area to buttock area for infection control and to prevent things from the rectum going to the genital area.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review, the facility failed to ensure the kitchen was free from pests. The sample was 12. The census was 47. Review of the facility's pest control logs, showed:-On 9/25/25, the pest control company treated the facility and observed insects in the kitchen;-On 10/6/25 the pest control company changed out the facility pest traps. Observation on 10/7/25, of the kitchen, showed:-At 10:41 A.M., multiple flies flew around the bulk bin area. Observation on 10/9/25, of the kitchen, showed:-At 9:28 A.M., multiple flies near the clean pots and pans;-At 9:41 A.M., a beetle crawled on the ground next to the oven. During an interview on 10/10/25 at 8:43 A.M., Dietary Aide S said the kitchen has insects and a pest control company comes to spray. During an interview on 10/10/25 at 8:48 A.M., the Dietary Director said he expected the kitchen to be free from insects. He said a pest control company comes out to spray and treat the kitchen around once a month. During an interview on 10/10/25 at 10:14 A.M., the Administrator said she expected the kitchen to be free from insects.