

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER St Louis Altenheim		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>Based on interview and record review, the facility failed to ensure one resident's (Resident #3's) representative/power of attorney was able exercise his/her rights to refuse medical treatment on behalf of the resident. The sample was four. The census was 44.</p> <p>Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/15/25, showed:</p> <ul style="list-style-type: none"> -Diagnoses included Parkinson's disease (brain disorder causing unintended or uncontrolled movements), anxiety, and unspecified lump in left breast; -Brief Interview for Mental Status (BIMs) should not be conducted. Resident is rarely/never understood. <p>Review of the resident's care plan, dated 5/20/25, showed:</p> <ul style="list-style-type: none"> -Focus: The resident has a terminal prognosis and admitted to hospice care; -Goal: The resident's comfort will be maintained through the review date; -Interventions: Adjust provision of activities of daily living (ADLs) to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate. Work cooperatively with hospice team to ensure the resident' spiritual, emotional, intellectual, physical and social needs are met. Work with nursing staff to provide maximum comfort for the resident. <p>Review of the resident's progress notes, showed:</p> <ul style="list-style-type: none"> -A note, dated 5/8/25, written by a Nurse Practitioner (NP) for an outside wound management company showed: -Patient presents today for evaluation and treatment of open wound/skin lesion. I certify the following reasons meet medical necessity for this encounter procedure(s) performed at this encounter that is outside the scope of practice of an licensed practical nurse (LPN) or registered nurse (RN) to perform. Prescription medication was ordered/recommended at this visit. Further diagnostic testing or examination was performed or ordered at this encounter. Education/counseling was provided to the patient regarding compliance and adherence with treatment plan. Bedside nurse was instructed on proper dressing changes or dressing change techniques to enhance wound healing; <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Minor Procedures: Surgical incision and drainage of left breast: Verbal consent was obtained before procedure. Education given on benefits and risks that can occur with incision and drainage. Resident acknowledged understanding and has no further questions;</p> <p>-Procedures: 22 blade scalpel was used for incision of mass to wound bed. Lidocaine 2% (local anesthetic) used for anesthetic prior to sharps debridement (procedure to remove dead, damaged, or infected tissue from a wound). Betadine (topical antiseptic) was used for cleansing purposes of wound bed before any insertion of sharps into tissue. Anticoagulant (blood thinner) use was reviewed prior to procedure. Heavy purulent (thick yellow/green) drainage during procedure, pressure dressing applied with successful coagulation. Post procedural pain: 0/10 per patient report. Post procedure measurements: 9 x 3 x 8.6 centimeter (cm) incision, Surface area incised: 27 cm²; Will follow up in one week;</p> <p>-Time spent today with resident was 35 minutes. Preparing to see the client, reviewing lab(s) or other test results, receiving report from the client and/or family and/or other caregiver, evaluating and assessing wounds and/or skin issues, educating bedside nurse on wound conditions and/or skin issues and/or dressing changes, educating client on condition and/or reinforcement of plan of care, ordering medications and/or tests and/or procedures, documenting clinical information in the health record.</p> <p>During an interview on 5/30/25 at 12:06 P.M., the resident's adult child said that neither he/she nor his/her sibling, who is the resident's power of attorney (POA), were informed that the wound management company staff were coming to the facility to perform a procedure on the resident's left breast on 5/8/25. The family was not informed by the facility that the procedure was done. They were informed on 5/9/25 by the hospice employee who came to the facility that the procedure was done on 5/8/25. The resident was unable to consent to the procedure himself/herself and would not have wanted the procedure done according to his/her power of attorney. The resident's POA would not have consented to the procedure had he/she been made aware in advance. After the procedure on 5/8/25, the resident was in pain, requiring morphine, and stopped eating.</p> <p>During an interview on 5/30/25 at 2:12 P.M., the Hospice Admission's Nurse said the resident's hospice team was not informed the resident was to have a procedure done on the resident's left breast by the wound management company on 5/8/25. On 5/9/25, a hospice nurse came to the facility to provide services and was notified that the procedure was done. The family was not informed of the procedure and would not have consented. The resident was not cognitively able to make his/her own decisions, and his/her POA was making medical decisions on his/her behalf. The resident was in more pain than normal after the procedure and required morphine.</p> <p>During an interview on 5/30/25 at 2:30 P.M., the Administrator and Director of Nursing (DON) said they did not get permission from the resident's power of attorney prior to the wound management team coming to the facility and performing the lancing on the resident's left breast. They said the family signed a consent form on 5/24/24 giving permission for wound management to provide services to the resident. They did not consider the lancing to be a procedure but normal care.</p> <p>MO00254669</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff oversight of one resident in the shower, resulting in the resident falling (Resident #1). The sample was four. The census was 44.</p> <p>The Administrator was notified on 5/30/25, of the past non-compliance. The facility gave certified nursing assistant (CNA) C a written warning and educated him/her on the importance of not leaving residents alone in the shower and gathering needed supplies before the shower. Maintenance staff audited all shower chairs to ensure they were in working order. Nursing staff were in-serviced on not leaving staff alone in the shower. The deficiency was corrected on 4/24/25.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/31/25, showed:</p> <ul style="list-style-type: none"> -Diagnoses of diabetes, epilepsy (seizures), and acquired absence of left and right leg above the knee; -Cognitively intact. -Substantial/maximum assistance from staff needed with transferring in and out of the shower. <p>Review of the resident's progress notes, showed a note, dated 4/7/25, called to resident's room by resident's roommate who stated resident was on the floor. Upon entering the room, resident was sitting up with his/her buttocks on the floor next to the bed. The bed was noted to be in the lowest position. Resident stated he/she was self-transferring and fell. Resident stated he/she did not hit his/her head, arm, back or buttocks. Resident given call-light and educated on use and asking for assistance. Resident stated understanding, range of motion done with no loss, call placed to emergency contact, physician, and Director of Nursing (DON) made aware of fall. Neurological checks in progress, plan of care ongoing.</p> <p>Review of the resident's care plan, in use at the time of the investigation, showed:</p> <ul style="list-style-type: none"> -Focus: The resident has had an actual fall with no injury on 4/22/25 due to above knee amputations, anxiousness, poor balance, and poor communication/comprehension; -Goal: The resident will resume usual activities without further incident through the review date; -Interventions: Per resident request, to have assist times one at all times while showering. Also request staff member remains in the shower room the entire time. <p>Review of the facility's fall scene investigation report, dated 4/22/25, showed:</p> <ul style="list-style-type: none"> -Date of fall: 4/22/25; -Time of fall: 10:50 A.M.; <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Fall description details: Factors at the time of fall indicated equipment malfunction;</p> <p>-Fall summary: Found on the floor in the resident's shower, unwitnessed fall;</p> <p>-Resident stated he/she was just taking a shower when the chair fell apart. The shower chair has arms that are removable;</p> <p>-Neurological checks attached were completed after the fall.</p> <p>During an interview on 5/30/25 at 9:56 A.M., the resident said on 4/22/25, he/she was in the shower chair in the shower in his/her room when CNA C told him/her that he/she was going to go get more towels. He/She said while alone in the shower, the shower chair broke and he/she fell onto his/her back and hit his/her head on the wall. He/She was not injured, but the fall was painful. Staff came right away and assessed him/her before getting him/her off the floor.</p> <p>During an interview on 5/30/25 at 7:43 A.M., CNA D said he/she was working on the resident's floor but was not assigned to the resident on 4/22/25. He/She said the shower chair had been moved to the spa room because it was broken. He/She said CNA C used the shower chair anyway, even though he/she knew it was broken. CNA C got the shower chair from the spa room and took it to the shower in the resident's room and put the resident on it. CNA C left the resident to go get towels and while he/she was gone, the resident fell.</p> <p>During an interview on 5/30/25 at 11:27 A.M., Housekeeper B said he/she was working on the resident's hallway when the fall occurred on 4/22/25. He/She saw CNA C leave the resident in his/her room in the shower and told him/her that he/she should not be leaving the resident alone. CNA C ignored him/her and left to go get towels. Housekeeper B went to the nurse and reported that CNA C had left the resident alone. CNA C was aware that the shower chair used was broken, prior to the resident's fall, and the chair had been placed in the spa to prevent it from being used. CNA C went to the spa room and got the shower chair to use it, knowing it was broken. Housekeeper B did not witness the fall. Since the incident, the shower chair was removed by maintenance and fixed.</p> <p>During an interview on 5/30/25 at 1:41 P.M., CNA C said on 4/22/25, he/she was giving the resident a shower, and the resident had a bowel movement (BM). CNA C left the room to go get towels and while he/she was gone, the shower chair broke resulting in the resident's fall. The resident was assessed and neurochecks were initiated. The resident did not have any injuries. CNA C did get the shower chair from the spa room but was unaware that it was broken. The resident should not have been left alone, and CNA C was given a warning by the Administrator and educated on gathering supplies before bringing residents into the shower.</p> <p>During an interview on 5/30/25 at 1:53 P.M., the Administrator and DON said the resident's fall was a result of the shower chair breaking while the resident was on it. They said the shower chair was fixed and maintenance staff checked other shower chairs to ensure no other chairs were broken. CNA C was given a verbal warning and educated on not leaving residents in the shower alone. They would expect staff to gather towels and supplies before bringing the resident into the shower. They would expect staff to ensure the shower chair is not broken before using it.</p> <p>MO00253458</p>		