STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A484	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 Note: The nursing home is disputing this citation.	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 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