

Missouri Department of Health and Senior Services

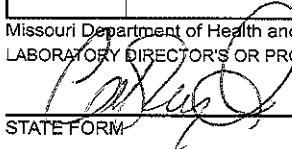
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2024
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NAME OF PROVIDER OR SUPPLIER MATTIS POINTE-ASSISTED LIVING BY AMERICARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4962 MATTIS ROAD SAINT LOUIS, MO 63128
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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A8023	<p>19 CSR 30-88.010(23) Develop/Implement A/N Policies</p> <p>The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III</p> <p>This regulation is not met as evidenced by: Class II*</p> <p>Based on interview and record review, the facility failed to follow their abuse and neglect policy when an alleged incident of abuse occurred and employees were allowed to continue to have contact with residents, for one of one sampled resident. (Resident #1) The census was 28.</p> <p>Review of the facility's undated "Reporting Abuse to Facility Management" policy, showed the following:</p> <p>-Guideline: It is the responsibility of our employees; and facility consultants, to promptly report any incident or suspected incident of resident neglect; or abuse, including injuries of unknown source/origin, and theft or misappropriation of resident property to facility management.</p> <p>-Procedural Steps:</p> <ol style="list-style-type: none"> 1. Our facility does not condone or tolerate abuse of residents. 2. Employees, facility consultants and/or attending physicians are to report any suspected abuse or incidents of abuse to facility 	A8023		
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Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
Admin

(X6) DATE
6/21/24

Missouri Department of Health and Senior Services

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A8023	<p>Continued From page 1</p> <p>management.</p> <p>3. The administrator and director of nursing services are to be notified of suspected abuse or incidents of abuse as soon as possible. If such incidents occur or are discovered after hours, facility management should be called at home or paged and informed of such incident.</p> <p>4. When an actual case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the following persons or agencies should be notified:</p> <p>All alleged or suspected cases should be reported to the respective State agency.</p> <p>a. The state licensing/certification agency responsible for surveying/licensing the facility;</p> <p>b. The resident's representative (sponsor) of record;</p> <p>c. The resident's attending physician;</p> <p>5. Notices to the above agencies/individuals may be submitted via US mail, special carrier, fax, email, or by telephone. Such notices include:</p> <p>a. The name of the resident;</p> <p>b. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc);</p> <p>c. The date and time the alleged incident occurred;</p> <p>d. The name(s) of all persons involved in the alleged incident; and</p> <p>e. What immediate action was taken by the facility.</p> <p>6. All personnel, resident's family members, visitors, etc are encouraged to report incidents of resident abuse or suspected incidents of abuse. Such reports may be made without fear of retaliation from the facility or it's staff.</p> <p>7. To assist in recognizing incidents of abuse, the following definitions of abuse are provided:</p> <p>a. Abuse if defined as the willful infliction of injury; unreasonable confinement; intimidation; punishments with resulting physical harm, pain or</p>	A8023		



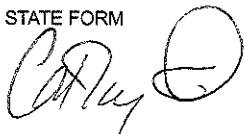
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A8023	<p>Continued From page 2</p> <p>mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well being.</p> <p>b. Verbal abuse is defined as any use or oral, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents regardless of their age, ability to comprehend, or disability.</p> <p>f. Mental abuse is defined as, but is not limited to humiliation, harassment, threats of punishment, or withholding of treatment or services.</p> <p>8. Any individual observing an incident of resident abuse or suspecting resident abuse should promptly report such incident to a member of the nursing staff or to management.</p> <p>Review of Resident #1's face sheet, showed the following: -The facility admitted the resident on 9/20/22; -Diagnoses included diabetes, dementia, and major depressive disorder.</p> <p>Review of the resident's nurses notes, showed the following: -Behavior note on 5/17/24 at 2:23 P.M., the resident had no issues today just couldn't find his/her purse for a minute but it was in his/her closet; -Behavior note on 5/18/24 at 1:59 P.M., Certified Medication Aide (CMA) went in resident's room that morning and the resident had his/her clothes everywhere. His/her microwave was hanging off the counter. He/she had his/her vacuum plugged in and water was on the carpet like he/she had let the sink run over. All types of things were in his/her sink. Clothes were all on the floor, bathroom had stuff everywhere. He/she said someone kept coming in his/her room messing</p>	A8023		
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A8023	<p>Continued From page 3</p> <p>up his/her room as he/she wouldn't do those things. Everything in his/her medicine drawer was soaking wet. He/she pulled his/her clothes out of the closet and said his/her family did it when he/she wasn't there. His/her family called him/her that morning and he/she told the family he/she fell out of the bed the night before. The CMA asked the resident about the fall but he/she said he/she didn't remember telling his/her family that;</p> <p>-Behavior note on 5/18/24 at 9:15 P.M., the resident told both CMA's on shift that a black woman with "natural hair" was on the couch in the resident's room. Resident also said upon waking up, the woman ran out of the room. Resident was very forgetful throughout the shift;</p> <p>-Behavior note on 5/27/24 at 10:16 P.M., the resident said staff told him/her it was time for him/her to move out so he/she started to pack his/her room;</p> <p>-Behavior note on 5/30/24 at 2:33 P.M., the resident was concerned items are being moved around his/her room;</p> <p>-Behavior note on 5/31/24 at 7:19 P.M., today resident had a great morning. Resident had lunch and dinner in the dining room and went to bingo after dinner around 6:30 P.M. CMA B went to check on resident and to give the resident his/her medications. The resident was in his/her chair upset. CMA B asked the resident what was wrong and resident said he/she was sick of this place and being told what to do. CMA B was giving the resident his/her medications when he/she hit the medication cup out of CMA B's hand. As CMA B was picking up the medications, he/she asked the resident was he/she refusing to take his/her medications. The resident said he/she was not going to take them. CMA B contacted the resident's power of attorney (POA) to inform him/her of the issue he/she was having</p>	A8023		



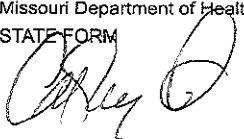
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A8023	<p>Continued From page 4</p> <p>with the resident. CMA B and POA agreed they would give the resident time to get him/herself together. When CMA B returned to ask resident if he/she was going to take his/her medications, the resident became very aggressive with CMA B and tried to leave out the front door of the community. CMA B asked for help from CMA A at that time, and the resident then threatened CMA B and grabbed CMA B by the arm and told him/her to shut up. CMA A tried to talk to the resident to get him/her to return to his/her room because the resident was trying to leave out the front door but the resident was refusing. POA and staff were made aware of the resident's behavior;</p> <p>-Behavior note on 6/2/24 at 12:51 A.M., the resident was upset about incident from previous day, said his/her feelings were hurt. Other than that, no unusual behaviors to report.</p> <p>Review of the resident care plan (individualized service plan) dated 6/2/24, showed the following: -Special Considerations: I have a history of anxiety, depression and agitation. I tend to get very upset easily, and tend to lash out at staff and my family. I am being followed by a psychiatrist for these behaviors. I have had a decline in cognition and memory impairment. I have been overflowing my sink in my room, as I am forgetting my faucet is running. I do not have any recollection of these events occurring. I have paranoid and obsessive compulsive disorder behaviors as well. I tend to think people are stealing items from my room, my money and other items. I tend to horde things in my room as well. Per my family's request, the sink has been turned off in the kitchenette area.</p> <p>Review of the facility's self report dated 6/2/24, showed the Administrator received a text message on Friday, 5/31/24, from an employee</p>	A8023		
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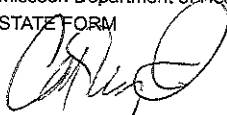
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A8023	<p>Continued From page 5</p> <p>(CMA A), which informed the Administrator and the Director of Nursing (DON), there was an altercation between a resident and a staff member (CMA B) regarding the resident refusing to take his/her medications. The Administrator and DON reviewed the cameras and could see the resident and employee "having words with one another." It was observed that the resident grabbed a hold of CMA B's right forearm, and CMA B pulled his/her own arm backwards and was free from the residents' hands. At no time, was there physical contact from CMA B towards the resident. The Administrator was able to talk to the resident on the phone and was able to calm the resident down. The resident told the Administrator that CMA B was "being rude" to him/her but did not indicate any kind of verbal or physical abuse. On 6/2/24, CMA B called the Administrator and said the resident's family had been told by CMA A that CMA B had cussed and "laid hands" on the resident. The Administrator spoke to the resident's family who said an employee had informed him/her of the altercation on Friday evening and he/she did not want CMA B to take care of the resident. The Administrator and DON went to the community around 9:45 A.M., interviewed CMA B and placed him/her on leave pending an investigation.</p> <p>Review of the facility's investigation summary dated 6/5/24, showed CMA B engaged in a verbal altercation which included using obscene language with the resident. Based on resident, family member, and staff interviews, it was determined CMA B had used inappropriate language with the resident. CMA B was terminated on 6/5/24, and a performance counseling was given to CMA A regarding not sharing concerns of abuse and neglect to management. All staff were inserviced on 6/5/24,</p>	A8023		
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A8023	<p>Continued From page 6</p> <p>on abuse and neglect and when to report.</p> <p>During an interview on 6/10/24 at 12:33 P.M., the Administrator said CMA A contacted her during the altercation but did not elaborate on the extent of the situation or give indication of potential abuse. She said she spoke to the resident to assist with calming him/her down and the resident informed her that CMA B was being rude to him/her. She said she did not ask additional questions about what specifically CMA B did or said to understand how he/she was being rude. She said there could always be more questions to ask but she had not asked any additional questions to fully understand the extent of the treatment of CMA B to the resident. She said had more questions been asked during the altercation, she could have placed CMA B on leave sooner. As a result, CMA B worked an additional shift on 6/1/24, placing other residents in a situation for potential harm.</p> <p>*The higher classification merited due to the extent of the violation.</p> <p>MO00237014</p>	A8023		




PLAN OF CORRECTION

Provider/Supplier Name:	Mattis Pointe- Assisted Living by Americare
Street Address, City, Zip:	4962 Mattis Road, St. Louis, MO 63128
Date of Survey:	06/10/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	
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A8023	19 CSR 30-88.010 (23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III	7/15/2024
	The facility will ensure to follow the abuse and neglect policy when an alleged incident of abuse occurs. Employees that are alleged/suspected of abuse and neglect will be suspended pending further investigation and not continue to have contact with residents until investigation can be completed.	
	All residents who reside at the facility are considered at risk for this deficient practice.	
	CMA B was terminated on 6/5/24	
	CMA A received a performance counseling and reeducated on reporting concerns of alleged abuse and neglect to management on 6/5/24	
	Administrator and or designee in-serviced all staff on abuse and neglect policy and how to report suspected abuse and neglect on 6/5/24.	
	Regional Nurse consultant and/or designee to in-service Administrator and Director of Nursing by 7/12/2024 on facility abuse and neglect policy and employees that are alleged/suspected of abuse and neglect will be suspended pending further investigation and not continue to have contact with residents until investigation can be completed.	
	Administrator and/or designee will monitor for continued compliance ensuring that all staff members receive abuse and neglect training and reporting requirements prior to or on first day of working in the facility and annually.	
	Administrator will report continued compliance to Regional Director of Operations monthly on Administrator monthly report.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.


Cathy Immel 6/21/24