STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265585	A. Building B. Wing	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Rehab and Healthcare Center	1265 McLaran Avenue Saint Louis, MO 63147

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 - Potential for minimal harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Please refer to event ID Q9F512 Statement of Deficiencies. 44707 This deficiency is uncorrected. For previous examples, please see the Statement of Deficiencies dated 1/25/22. Based on observation, interview and record review, the facility failed to provide a safe, clean and comfortable, homelike environment. The facility failed to unclog two sinks in two residents' rooms (Residents #63 and #76), and one sink in an unoccupied room that was accessible to residents from the hallway, failed to address wall damage exposing water dripping from a pipe behind the wall in Resident #63's room, and failed to address damaged ceiling tiles and stained walls in a lounge area commonly occupied by residents. Additionally, the facility failed to maintain the facility free from pests and mice. The sample was 7. The census was 124. 1. Review of Resident #63's electronic health record (EHR), showed: -Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/17/22, showed the resident was cognitively intact. Observation and interview on 4/27/22 at 10:30 A.M., showed the resident stood near the sink in his/her room. The sink basin was filled approximately halfway with water; black debris floated in the water. A gnat flew around the sink basin. The resident said the sink had clogged up and the facility knew it. He/she saw bugs in his/her room the previous night, motioning toward the floor beneath his/her sink. The wall beneath the sink had a large hole in it and plaster was exposed. A grayish-blackish discoloration seeped through the intact portion of the wall. A rust-colored screen lay immediately behind the hole. A pipe from behind the wall could be visualized. A small dribble of water dripped from the pipe, down into the inside of the wall in steady, equal increments. 2. Review of Resident #76's EHR, showed: -A quarterly MDS, dated [DATE], showed the resident was cognitively intact. (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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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Observation and interview on 4/28/22 at 7:02 A.M., showed the resident in his/her room, standing with his/walker, near the sink. The sink basin held brown fluid. The resident said he/she thought the sink was stopped up. It had been stopped up for about two weeks. He/she told the facility his/her sink was stopped up and they tried to fix it, but had not done a good job. 3. Observation on 4/28/22 at 6:46 A.M., showed room [ROOM NUMBER] unlocked and accessible from the hallway. A foul odor was present in the room. A brown, jellied-like substance filled the sink-basin approximately halfway. A brown crust lined the perimeter of the sink basin. Black debris was splattered across the floor, from beneath the sink, outward into the room. 4. Observation of the 3-main lounge area on 4/27/22 at 10:55 A.M., showed damaged, pattern-stained drop in ceiling tiles adjacent to a mounted television. [NAME] pattern-staining trailed down the wall beneath it. Multiple residents sat in the lounge area and were actively engaged in activities with a staff person. Further observation on 4/28/22 at 7:00 A.M., showed three residents sat in the 3-main lounge area. During an interview on 4/27/22 at 11:45 A.M., Certified Nursing Assistant (CNA) K said the double doors to the entrance of the 3-main lounge room remained opened to the residents because the vending machine is located in there. Residents could come into the room by themselves when staff were up the hall. During an interview on 5/2/22 at approximately 12:16 P.M., Resident #111 said the facility knew about the ceiling tile and wall damage in the 3-main lounge area; it had been like that for awhile. 4. Review of the facility's pest control log on 4/27/22 at 12:55 P.M., showed the facility had a contract with a pest control company. The facility last received pest control maintenance on 4/26/22 and it was recommended the gap/damage of the front entry doors be repaired because it allowed pest access. Environmental recommendations to prevent pest entry were also noted to be made at pest control service visits, dated 3/22/22, 4/1/22 and 4/12/22. During an interview on 4/27/22 at approximately 11:10 A.M., Maintenance Technician J, said he/she completes environmental rounds daily on the third floor. During this morning's rounds, he/she found three mice in room [ROOM NUMBER]. He/she threw them away. During an interview on 4/27/22 at approximately 9:43 A.M., Resident #88 said he/she heard bugs and mice in his/her room during the night. On 4/27/22 at 10:43 A.M., Resident #111 said the facility had cockroaches and was infested with mice. On 4/27/22 at 11:03 A.M., Resident #69 said bugs would come into his/her room from the storage room and he/she observed bugs near the trashcan in his/her room. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	5. During an interview on 4/28/22 at 8:11 A.M. the Maintenance Director said the maintenance department conducted environmental rounds daily. Each maintenance technician was assigned a specific unit to round and Maintenance Technician J was responsible for the third floor. During environmental rounds, maintenance technicians checked blinds, walls, sinks, and window units for damage. They were to make note of any damage seen. Standing water observed in a sink basin should have been noted during environmental rounds. He/she was told room [ROOM NUMBER] was vacant for a long time and he/she had been working to get it ready for occupancy. He/she treated room [ROOM NUMBER] for mice and mold, and had just opened the room back up. It is an old building with a lot of things to fix and the former administrator told him/her not to expect too much from the third floor. In a second interview with the Maintenance Director on 4/28/22 at 3:09 P.M., he/she said standing water seen in sink basins should be observed and noted during rounds. The water should be vacuumed from the sink basin and the pipe should be assessed. The j-pipes (curved shaped pipe in a drain pipe system) were too restrictive. He/she said an old leak had contributed to the damaged, stained drop-ceiling tiles seen in the 3-main lounge area. He/she cleaned the pattern-staining on the wall with a cleaning solution from the facility. During an interview on 5/2/22 at 1:43 P.M., the administrator said environmental rounds were being done daily and there were a couple of reports of clogged sinks turned into maintenance. Usually someone would work on them. He had not personally seen any clogged sinks in residents' rooms. Stained and/or damaged ceiling tiles and walls are recurring issues throughout the facility. The clogged sinks are a recurring issue. He said there was a lot of damage underneath sinks. The leak in Resident #63's room was new to him. Things with immediacy should be addressed. MO00198190 MO00198232 MO00198301

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview and record review, the facility failed to ensure a resident received appropriate person-centered care and met their highest practicable psychosocial well-being when the facility failed to provide assessment and mental health services for one sampled resident with a known history of suicidal ideation and attempts (Resident #68). The facility failed to address the family's concerns when they made the facility aware, on more than one occasion, the resident was exhibiting increased anxiety related to past sexual abuse. The facility failed to obtain information regarding the resident's history of trauma, including the stressors and triggers of the trauma. The resident stated he/she jumped out a third floor window in an attempt to commit suicide. This resulted in the resident sustaining a broken back and two broken legs on 4/2/22. The resident returned to the facility on [DATE] and the facility failed to implement any interventions to support the resident's mental and emotional well-being. On 4/27/22 the resident was sent to the hospital after making several attempts to wrap the call light cord around his/her neck. The sample was 7. The census was 124. The administrator was informed on 4/28/22 of an Immediate Jeopardy (IJ), which began on 4/27/22. The IJ was removed on 5/2/22 as confirmed by surveyor on-site verification. Review of the facility's Behavioral Health Services policy, revised February 2019, showed: -Policy Statement: The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practical, physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care; -Policy Interpretation and Implementation; 1. Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care; 2. Residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care; 3. Residents who do not display symptoms of, or have not been diagnosed with, mental, psychiatric, psychosocial adjustment, substance abuse or post-traumatic stress disorder, will not develop behavioral disturbances that cannot be attributed to a specific clinical condition that makes the pattern unavoidable; 4. Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress; 5. Staff training regarding behavioral health services includes, but is not limited to; a. recognizing changes in behavior that indicate psychosocial distress; (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs; c. monitoring care plan interventions and reporting changes in condition; d. protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post-traumatic stress disorder; 6. Behavioral health services are provided by staff who are qualified and competent in behavioral health and trauma-informed care; 7. Staff are scheduled in sufficient numbers to manage resident needs throughout the day, evening and night. Review of Resident #68's medical record, showed: -admitted on [DATE]; -Diagnoses included Alzheimer's disease, restlessness and agitation, unspecified psychosis (a mental disorder characterized by a disconnection from reality), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), major depressive disorder and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of the resident's Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure individuals are not inappropriately placed in nursing homes for long term care), dated 5/4/16, showed: -The resident met the federal definition of Serious Mental Illness (SMI) but does not require specialized services. Please incorporate the lesser intensity services into the resident's care plan; -Does this person show any signs or symptoms of major mental disorder? Yes, lability of mood and disorganization of thoughts; -Has this person ever been diagnosed as having a major mental disorder? Yes, bipolar disorder with psychosis; -Is the primary reason for nursing facility placement due to dementia, including Alzheimer's disease or related disorder? No; -Has the person had serious problems in levels of functioning in the last six months? Yes; -Has the person received intensive psychiatric services in the past two years? Yes. Review of the resident's progress notes, showed: (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-12/2/16 at 3:39 P.M., Report from social services stated resident was asked if he/she was having any suicidal thoughts and if so, how would he/she act on them. Resident stated that he/she is not currently having suicidal, however, if he/she was, he/she would use a razor. Staff for oncoming shift made aware; -1/26/17 at 11:45 P.M., Resident came to this nurse and stated that he/she is feeling suicidal. When asked what his /her plan was, resident stated he/she would cut his/her wrist. Call placed to the psychiatrist. Received new orders to send to the hospital for a psychiatric evaluation. The psychiatrist said he would call the hospital and let them know the resident was coming; -5/24/18 at 1:02 P.M., Resident informed this nurse that he/she had been waking in the middle of the night with suicidal ideation. The resident stated that he/she has formulated a plan and if he/she were to try to commit suicide, he/she would cut him/herself. The resident denied any thoughts at the present moment. The nurse spoke to the psychiatrist and he has informed this nurse to monitor the resident for signs of increased depression and to notify him of any changes in mood or behavior. Social services has been made aware; -3/31/19 at 1:40 P.M., Resident made this nurse aware that he/she was feeling suicidal. Resident stated that he/she was talking to some of the residents about it while smoking. When asked what his/her plan was, he/she stated he/she did not know. When asked why he/she felt that way, resident stated he/she only received one Ativan (anxiety medication) last night. Resident encouraged to always come to staff when feeling suicidal or depressed. Resident was asked again why he/she feels that way and he/she stated he/she spoke to his/her parent last night and told the parent, Fuck you. Resident then stated that his/her parent wanted to talk about what was bothering him/her but he/she did not. Resident also stated that he/she does not like to talk about his/her feelings. Resident was asked what would make him/her feel better and resident stated a soda and Ativan. Medication and soda given to resident. Will continue to monitor mood; -12/1/20 at 3:10 P.M., Social worker met with resident to follow up from an earlier suicide assessment that was completed earlier today. SW discussed the suicide assessment score with the resident. SW reviewed three questions and answers with the resident that he/she answered. About once a week and a couple of times a month. 1. I thought about killing myself. Answer: about once a week. Resident states he/she had not thought about killing self weekly, just twice a month because of his/her parent's temper; 2. I thought about how I would kill myself. Answer: About once a week. Resident states, I have no plans to kill myself. Resident states he/she has thought about it before about two weeks ago, but not on how he/she would follow through; 3. I thought about when I would kill myself. Resident states he/she thought about dying today because his/her parent thinks the resident is dying or if the resident leaves the facility, he/she will do bad things. SW spoke to the resident about coping skills that he/she used to decrease thoughts of killing self. Resident says he/she reads books, talks with peers and sits in the kitchen looking out of the window. Resident states the coping skills are effective. SW will reach out to the psychiatrist to share suicide assessments and answers; (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-7/13/21 at 8:20 A.M., The resident refused to allow staff to get him/her up and dressed for parent's funeral today and stated he/she did not feel like getting up and did not want to go to the funeral. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/2/21, showed: -Cognitively intact; -Feeling down and depressed occurred never or one day; -Experienced delusions; -Verbal behaviors toward others occurred one to three days per week; -Wandering occurred one to three days per week; -Not receiving psychological therapy. Review of the resident's Psychiatric Follow-Up Evaluation, dated 10/18/21, showed: -Content of thought within normal limits; -Poor insight, judgement and decision making skills; -Diagnoses: Bipolar and depression; -Assessment: Patient doing well. Review of the resident's progress notes, dated 11/1/21 at 6:18 P.M., showed this writer notified the medical director regarding this resident's disruptive, destructive and combativeness towards staff and peers. Received new order to send to the hospital for psychiatric care and behavioral management. Review of the resident's quarterly MDS, dated [DATE], showed: -Mild cognitive impairment; -Exhibited no behaviors; -Not receiving psychological therapy. Further review of the resident's progress notes, dated 2/21/22 at 3:36 P.M., showed the Social services director (SSD) received a call from the resident's sibling regarding his/her overall care and was concerned about incidents told to him/her by the resident. Review of the resident's annual MDS, dated [DATE], showed: (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Cognitively intact; -Wandered one to three days per week; -Does wandering place the resident at significant risk of getting to a potentially dangerous place? Yes. -Not receiving psychological therapy. Review of the resident's medical record, showed staff did not document a Wandering Assessment prior to 3/1/22. Further review of the resident's progress notes, showed: -3/22/22 at 12:28 P.M., SSD spoke with the resident's sibling/representative, who requested a care plan meeting and informed the facility that he/she is now the appointed Power of Attorney (POA, a legal document that allows someone to act on behalf of someone else); -3/23/22 at 1:43 P.M., SSD met with the MDS coordinator and the resident's POA for care planning purposes. Outside counseling was discussed as a method to assist with the resident's past traumas and how they trigger him/her. POA discussed the possibility of transferring the resident to a different state to be closer to family. Resident does not currently want to go. SSD stated staff can monitor the resident's desires on this matter. MDS coordinator addressed the resident's need for a specialty care unit if he/she were to transfer due to current diagnoses and behaviors. During an interview on 4/28/22 at 10:48 A.M., the SSD said the resident's sibling/POA contacted her and expressed concerns because the resident was becoming increasingly agitated and anxious. She made a referral to a counseling service at that time. She could not recall if she followed up on the referral. Review of the SSD's email exchange regarding counseling services for the resident, provided by the SSD on 4/28/22 at approximately 12:30 P.M., showed: -On 3/23/22 at 10:07 P.M., an email to the counseling services: Can we add Resident #68 to your client list? -On 3/27/22 at 7:18 P.M., a response from counseling services: To add someone on to services, you will need to submit their face sheet, a doctor's order, and the consent from the guardian/POA either online or by fax. I've courtesy copied (counseling service staff), who can help you with any questions during the process; -On 3/28/22 at 8:40 A.M., the SSD sent an email to the Director of Nursing (DON): Are we able to get a doctor's order for counseling services for Resident #68?; -No further email exchanges. During an interview on 4/28/22 at 2:12 P.M., the resident's sibling/POA said he/she never received a call regarding a referral for counseling services. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the resident's progress notes, showed: -3/29/22 at 3:01 P.M., Resident's sibling/POA called SSD to discuss concerns raised by a phone call from the resident yesterday evening. Resident sounded full of anxiety and urgency in needing sibling to call him/her back. SSD stated a visit was just completed and after observation, the resident appeared to be at his/her baseline. The sibling was concerned because the resident was not alert and oriented to his/her location regarding state (resident knew he/she was at the facility but thought he/she was in a different state). SSD explained that due to diagnoses and memory challenges, that was unfortunately normal for some residents. However, this information would be passed along to the MDS coordinator and nursing team. -4/2/22 at 3:24 P.M., This nurse was sitting at the nurse's station when this nurse heard another resident scream the resident's wheelchair was by the window. This nurse immediately ran into the resident common area where seating and vending machines are located. When glancing quickly over the common area, the resident was not seen. This nurse, certified medication technician (CMT) and certified nursing assistant (CNA) immediately began to do room checks. As room checks were being completed a code yellow (code for a missing resident) was called. The nurse and CMT then ran off the unit while the CNA stayed on the unit. This nurse and CMT then ran out of the facility and around the building looking for the resident. This nurse could see the CNA from the third floor and said the resident was on the roof. This nurse, CMT and another CMT from another hall ran into the back of the building and up the stairs to the third floor. Two men working at the facility attempted to open the windows but they would not open. Staff went to a lower level, then one of the men was able to open one window. The nurse and CMT from another floor climbed out of the window and saw the resident lying on his/her left side with some blood on the rocks near his/her face. Staff then threw a sheet and a blanket out of the window and the CMT from the other hall covered him/her up. Emergency medical services (EMS) arrived and came through the window. They applied a c-collar (a medical device used to support a person's neck) to the resident's neck and rolled him/her onto a backboard and carried him/her back into the building. This incident occurred between 12:10 P.M. and 12:12 P.M. Review of the resident's hospital record, showed: -Patient was admitted on [DATE] at 12:52 P.M.; -Chief Complaint, fall; -Patient with diagnoses of Alzheimer's disease and Bipolar disorder with major depressive disorder/psychosis, presenting after fall from height with multiple orthopedic injuries. Patient attempting to escape his/her psychiatric facility and drive to Cincinnati jumped off the third story window onto the second floor balcony. Injuries include L2 (second vertebra in lower back), L5 (fifth lumbar spine vertebra) burst fracture with retropulsion (any vertebral fracture fragment displaced into the spinal canal, potentially causing spinal cord injury), L1 superior end plate deformity (portion of the spinal cord), right [NAME] fracture (a type of break of the shinbone that happens near the ankle), left medial malleolus fracture (bump that protrudes on the inner side of the ankle), comminuted talus fracture (fracture due to high energy impact and are frequently open fractures), gluteal (general region of the buttock) hematoma, celiac artery dissection (a type of arterial dissection), left external iliac dissection (disease caused by trauma) and nasal bone fracture. Review of the facility's Self-Report Investigation, dated 4/7/22, showed: (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 12:10 P.M., a code yellow was called for third floor south. It was communicated that the resident was missing and staff started checking rooms and facility grounds. The resident was observed on the second floor balcony at about 12:14 P.M. Resident stabilized by staff by 12:20 P.M., approximately. At about 12:30 P. M., the resident was transported by EMS to the hospital; -Staff and Resident Interviews; -Interview with Resident #76: Resident states that he/she went into the 300 south lounge to get some chips, and stood by the vending machine next to the window. While at the vending machine, he/she could not see the machine because the wind coming through an open window was blowing his/her hair into his/her face. He/she closed the window and noticed Resident #68's wheelchair at that window. Resident stated he/she went to the hall and yelled, Resident #68's wheelchair is at the window. I don't see (him/her); -A resident psychosocial well-being assessment was performed on other residents on the 300 hall locked behavioral unit and none expressed concerns about feeling unsafe, wanting to self-harm or fearfulness of others; -CNA A saw the resident in room [ROOM NUMBER] at approximately 11:40 A.M. on 4/2/22; -CMT B, Nurse C and CNA A stated Resident #76 yelled out that Resident #68's wheelchair was in the 300 South lounge area but Resident #68 was not in the 300 south lounge at approximately 12:10 P.M.; -Findings: Resident #68 is alert and oriented with a primary diagnoses of Alzheimer's disease, anxiety disorder, depression and unspecified psychosis. Resident is cognitively intact; -Conclusion: -Resident #68 lives on the locked behavioral unit on the third floor since 5/23/16 for most of his/her residency in the facility. Resident is noted to be alert and oriented to person, place and time, cognitively intact and his/her own responsible party; -Since inception, the facility has had multiple levels of security to ensure resident safety to include magnet locks with keypad access and mechanical stops on all windows to prevent windows from fully opening to prevent potential incidents; -The facility's investigation concludes that Resident #68 exited the facility from the third floor window attempting to gain access to the second floor balcony. As a result, sustained multiple injuries. Further interview of the resident and review of hospital records indicate that his/her intention was to exit the facility and drive to Cincinnati; -Resident #68 has not displayed any recent negative behaviors that may include sadness, isolation, suicidal ideation, exit seeking or aggression; (continued on next page)

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	265585	A. Building B. Wing	05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Rehab and Healthcare Center	1265 McLaran Avenue Saint Louis, MO 63147

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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-It was found that Resident #68 was able to circumvent the mechanical stop that was preventing the window from fully opening. Our investigation was unable to prove how the resident was able to remove the mechanical stops as no items or foreign devices were found at the window or near the resident outside where he/she was found. Upon inspection of the window, it was found that a screw was lying on the right side of the window sill. The screw that was originally placed on the left side of the window was bent upward showing signs the window was forced upward to be able to be opened; -All windows on the locked behavioral unit were audited and checked for safety immediately, and subsequently all windows in the building were audited and deemed safe with mechanical stops in place. Environmental audits are on-going, all staff were educated on signs of psychosocial distress, elopement and resident safety, elopement and psychosocial assessments performed. During an interview on 4/27/22 at 9:54 A.M., Resident #68 said about a week ago, he/she was depressed and jumped from the third floor window in an attempt to kill him/herself. He/she jumped and landed on the first floor balcony and broke his/her back and legs. The window was a three panel window and he/she was able to open the window with no difficulties. He/she thought it happened around 1:00 P.M. No staff or residents were present when he/she decided to jump out of the window. He/she did not inform anyone the day of the incident that he/she was depressed and planned to try to commit suicide. He/she had not told the SSD about his/her plans. When asked if the resident spoke with the SSD about any of his/her concerns or any issues over the last six to eight months, the resident replied No. At the moment, he/she was not feeling suicidal or depressed. Review of the resident's Wandering Risk Assessment, dated 4/2/22, showed; -High risk to wander; -Has history of wandering; -Has medical diagnosis of dementia/cognitive impairment, diagnosis impacting gait/mobility or strength; -Has wandered in the past month. Further review of the resident's progress notes, showed: -4/14/22 at 3:32 P.M., the resident was readmitted from the hospital with multiple fractures and a turtle brace (Used to stabilize the spine after surgery or in the event of a spinal fracture to promote healing and decrease pain) to be worn at all times. Pins in the ankles and bruises from face to extremities, neck, thighs, back, total care, Hoyer (mechanical lift), bed rest, alert and oriented to person, place and time. Bed in low position; -4/14/22 at 11:54 P.M., the resident observed removing bandages, cast and tractions (a set of mechanisms for straightening broken bones or relieving pressure on the spine and skeletal system) in bilateral legs. Resident was advised to stop but was not compliant. Suture sites are now bleeding actively, bandages placed on site at this time. Ambulance has been called and awaiting transport to hospital at this time to rebandage and recast fracture sites; (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-4/15/22 at 5:47 A.M., resident returned from the hospital at this time. Alert and aware of surroundings. Review of the resident's Significant Change MDS, dated [DATE], which included the PHQ-9 assessment (Patient Health Questionnaire-9, assessment for depression), showed in the last 14 days: -Feeling down, depressed or hopeless? Yes, one day; -Poor appetite or overeating? Yes, one day; -Feeling bad about yourself-or that you are a failure or have let yourself or your family down? Yes, two to six days; -Thoughts that you would be better off dead, or of hurting yourself in some way? Yes, two to six days. During an interview on 4/28/22 at 10:48 A.M., the SSD said she worked at the facility since December 2021. She was responsible for the social services assessments. She also conducted Trauma Assessments, Initial Psychosocial Assessments and was responsible for the social services portion of the MDS. The MDS coordinator updated care plans when new issues arise. If it is an emergency situation, department heads can update the care plan. She was not sure why the resident fell from the window. She does rounds with residents on a daily basis and has been in communication with the resident's family member. The family member/POA would contact her and tell her the resident was agitated and would make statements. She explained to the resident's family member that due to resident's diagnoses, this was his/her baseline behavior. The resident never mentioned being depressed or suicidal. The family member/POA told the SSD the resident was dealing with past trauma and inquired about additional services for the resident, as he/she was becoming increasingly anxious. The SSD did not ask the family member what those past traumas were about. She told the family member she would follow up. Around 3/23/22, the family member/POA called her again because the resident was making concerning statements. The SSD said she did not ask the family members about the concerning statements. However, she told staff to watch the resident because he/she was agitated. The doctor was not notified about the resident's family concerns about his/her change of condition. She could not recall which staff she told to monitor the resident. The SSD inquired about an outside counseling service, but the DON was supposed to follow-up with the provider and she was not sure if the DON followed up. Nursing handles psychiatric services. The SSD said her own memory was not good so she wrote down information on note pads. On 2/21/22, the family member/POA called the SSD to discuss the resident's increasingly anxious behaviors. At that time, she told staff to monitor the resident closely. On 3/22/22, she spoke with the resident's family member/POA, who requested a care plan meeting. On 3/23/22, she met with the resident's family member/POA and the MDS coordinator. At that time, she did not discuss the resident's triggers or past trauma. On 3/29/22, she spoke with the resident after receiving another call from the family member/POA, and the resident was pleasant. The resident was alert and oriented and could make his/her needs known. She could not recall if she spoke with the resident's physician regarding the concerns the resident's family brought up about the increasingly anxious behaviors. Review of the resident's care plan, updated on 4/17/22, reviewed on 4/28/22 at 7:50 A.M., showed: -Focus: Resident is an elopement risk/wanderer related to history of attempts to leave facility unattended; (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Goal: The resident's safety will be maintained through the next review date. He/she will not leave the facility without supervision; -Interventions: Assess for fall risk. Identify pattern of wandering. The resident's triggers for wandering/eloping are de-escalated by medication administration. Monitor for fatigue and weight loss; -Focus: The Resident has impaired cognitive function at times related to Alzheimer's disease; -Goal: The resident will be able to communicate basic needs on a daily basis through the next review date; -Interventions: Administer medications as ordered. Ask simple yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Monitor and document any changes in cognitive function. Reminisce with the resident inquiring about family/friends. The resident needs supervision with all decision making; -The care plan did not address suicidal ideation or behaviors related to anxiety or agitation as of 4/28/22 at 7:50 A.M. Further review of the resident's progress notes, showed on 4/18/22 at 4:47 A.M.: -Monitoring during night. Alert and oriented during shift. Multiple attempts to remove upper body brace by resident. Unable to redirect. Places self on mattress to floor. Denies any pain or discomfort. Resident stated multiple times, Just let me die. I'm all broken. Denies hearing voices. Right lower extremities warm to touch. Some noted swelling. No active bleeding. Morning medication as ordered. Resident up in recliner; -No documentation staff notified the resident's physician of the resident's statements. During an interview on 4/28/22 at 2:09 P.M., the DON said the in-house psychiatric nurse practitioner (NP) was at the facility on 4/22/22 and she asked the NP to see the resident. Review of the resident's psychiatric evaluation, dated 4/22/22, showed: -Chief Complaint: The resident is being seen to establish with new psychiatric provider. He/she recently jumped out of the window of his/her third floor room. Facility relayed that patient told hospital staff he/she was attempting to elope out of state. He/she is calm and appears comfortable. He/she agrees to speak with this author; -Diagnoses: Bipolar disorder, restlessness and agitation, Alzheimer's disease, insomnia, unspecified psychosis, major depressive disorder, anxiety and schizophrenia; -Social History: History was provided by the resident, who is not a reliable historian; -Thought Content: Absent of suicide or homicidal intent; -Judgment: Poor; (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Insight: Poor; -Memory: Impaired; -Orientation: Alert and oriented to self; -Assessment: The resident exhibits latency in thought and speech. He/she answers with one word answers. Suspect long complicated psychiatric history and multiple self harming events and suicidal attempts but he/she is not forthcoming or may not recall. At this time, the resident denies thoughts of hurting him/herself. He/she denies all mood and psychotic symptoms. Will need to review chart further and attempt to collect a better history from a collateral source. As he/she is new to this author, baseline has not yet been established. Complexity of his/her mental condition is severe. Functionality is low. Further review of the resident's progress notes, showed: -4/27/22 at 10:08 P.M., resident asked staff member for a knife or gun so he/she could kill him/herself. Resident was yelling at staff, cussing them out, calling them names. Resident was trying to climb out of bed, continued to pull the call light out of wall. When asked to stop, he/she would just yell; -Staff did not document notifying the resident's physician of the change in status; -4/28/22 at 2:31 A.M., Nurse H was given in report from off going agency nurse resident has been verbalizing killing him/herself and placed call light around neck multiple times in an attempt to strangle self. Call placed to MD to make aware. MD ordered transfer to the hospital for a psychiatric evaluation. (continued on next page)

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