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	06/22/2022

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

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to provide a sanitary, comfortable and homelike environment. The facility failed to adequately address ongoing issues with leaking pipes in common areas, to empty a trashcan filled with water and garbage in a common area, and to maintain the facility free from mice. In addition, the facility failed to maintain comfortable temperatures in the first floor dining room, resulting in staff instructing residents on the first floor to eat in their rooms. The sample was 13. The census was 119. 1. Observation of the ground floor sitting area on 6/21/22 at 8:10 A.M., showed five ceiling tiles missing above a column at the center of the room, leaving pipes exposed. Two large bins sat in front of the center column. A hose from the ceiling dripped water into one of the bins. Five ceiling tiles were missing near the back of the room, leaving pipes exposed. Observation of the ground floor sitting area on 6/22/22 at 9:18 A.M. and at 11:57 A.M., showed four ceiling tiles missing upon entering the sitting area. Water dripped from the exposed pipes in the ceiling, into a plastic bin on wheels. Five ceiling tiles missing above a column at the center of the room, left pipes exposed. Water leaked from the pipes into four plastic containers positioned around the column, underneath the missing ceiling tiles. Against the back wall, five ceiling tiles missing, left pipes exposed. A hose from the ceiling drained water into a large trash can underneath the missing tiles. 2. Observation of the activity room on 6/21/22 at 10:05 A.M., showed nine ceiling tiles missing at the center of the room, leaving pipes exposed. Three ceiling tiles missing at the end of the room, left pipes exposed. An area of floor tiles, approximately 4 by 4 feet, were discolored and warped. 3. Observation of the first floor on 6/22/22 at 9:22 A.M., showed a missing ceiling tile in the hall outside of room [ROOM NUMBER]. There was a missing ceiling tile in the vending machine/sitting area at the end of the hall. A missing ceiling tile on the opposite side of the hall, across from the sitting area, with a plastic garbage bin, approximately 2.5 feet high and 2 feet in diameter, was positioned underneath the missing tile. The garbage bin was full of water, approximately 2 inches below the rim of the bin, with trash floating in the water, including two soda bottles, two Styrofoam cups, two empty potato chip bags and two face masks. 4. Observation of the first floor dining room on 6/22/22 at 9:25 A.M., showed the lights off. The room was warm with no air conditioning blowing from the unit against the back wall. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #42's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/15/22, showed the resident was cognitively intact. Observation on 6/22/22 at 10:02 A.M., showed pest droppings in the resident's closet. No pest traps were in the room. During an interview on 6/22/22 at 10:02 A.M., the resident said there are mouse droppings in his/her closet. There are mice all over the facility. When he/she turns on the bathroom light at night, the mice squeak at him/her. He/she just saw one the other day. He/she just moved rooms because the pipes burst in his/her old room and the room flooded. Pipes are still leaking throughout the facility. Staff put trash cans underneath the leaking pipes and it's not homelike. His/her quality of life is going down. The first floor dining room has been closed for two weeks. Staff said residents can't eat in there because it's too hot and now residents have to eat in their rooms. He/she enjoys going in the cafeteria because it's a place where people can socialize or get a little quiet time in between meals. 6. Review of Resident #402's quarterly MDS, dated [DATE], showed the resident was cognitively intact. Observation on 6/21/22 at 9:34 A.M., showed two sticky traps to the left of the resident's bed. During an interview, the resident said he/she still sees mice in his/her room and the sticky traps have not made the mouse situation better. 7. Review of Resident #406's quarterly MDS, dated [DATE], showed the was resident cognitively intact. During an interview on 6/21/22 at 10:05 A.M., the resident said there are pests everywhere in the facility. He/she sees mice up and down the hall and in rooms. It's been like this for months with no improvement. It's a shame it's like this. All staff and residents are aware of the mice. Within the last couple weeks, the pipes burst in the activity room and flooded the ground floor. Now the activity room looks horrible. Pipes are bursting everywhere and residents have to move rooms. It looks terrible. Staff put trash cans underneath the leaking pipes and the trash cans are filthy. The air conditioning has not been working in the first floor cafeteria, so residents have to eat in their rooms. Residents should not have to eat in their rooms. Meals are a time for people to get together and socialize. 8. Review of Resident #409's quarterly MDS, dated [DATE], showed the resident was cognitively intact. During an interview on 6/21/22 at 9:02 A.M., the resident said there are mice all around the facility. They run up and down the halls and in his/her room. He/she has seen mice during the last couple of days. He/she saw pest people here before, but the mice have not gotten better. 9. Review of Resident #408's quarterly MDS, dated [DATE], showed the resident was moderately cognitively impaired. During an interview on 6/21/22 at 9:29 A.M., the resident said he/she has mice in his/her room. The mice are up mostly at night. He/she almost killed one mouse in his/her room the previous night. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Review of Resident #39's annual MDS, dated [DATE], showed the resident was cognitively intact. During an interview on 6/22/22 at 9:54 A.M., the resident said residents on the first floor have been unable to eat in the cafeteria for weeks because staff said the room is too hot. Now residents are sentenced to eating meals in their rooms, including this morning's breakfast. He/she wants to eat in the cafeteria and does not enjoy spending all day in his/her room. 11. Review of Resident #407's quarterly MDS, dated [DATE], showed the resident cognitively intact. During an interview on 6/22/22 at 9:58 P.M., the resident said residents have not been able to eat in the first floor cafeteria for weeks. He/she likes to eat in the cafeteria where he/she can talk to people and socialize, but staff said residents are not allowed in there because of the high heat. He/she sees pipes leaking throughout the facility and doesn't like it. 12. During an interview on 6/21/22 at 9:12 A.M., Certified Medication Technician (CMT) J said the facility has mice and he/she sees them in all areas of the building at all times of the day. It bothers the residents that there are mice in the building. Pest issues are reported to maintenance. He/she has seen maintenance set traps for pests, but it is unknown how often this takes place. During an interview on 6/21/22 at 1:04 P.M., Certified Nurse Aide (CNA) I said there are lots of mice in the facility, especially upstairs. He/she has seen them recently. Nursing staff help address the pest issue by picking up food in resident rooms. 13. During an interview on 6/22/22 at 9:27 A.M., [NAME] G said the first floor dining room has been closed for several weeks because there is no air conditioning in the dining room or kitchen. It is too hot for the residents to eat in the dining room, so they have to eat in their rooms now. Residents spend the whole day in their rooms, and that is not considered homelike. It's not really fair for the residents to have to eat in their rooms. The pipes have been leaking in the hall on the first floor for weeks. There is a giant trash can in the hall to catch the water, and it's also full of trash. He/she would not like seeing that in his/her home. During an interview on 6/22/22 at 9:31 A.M., [NAME] F said the first floor dining room has been closed for about two weeks because there is no air conditioning in the dining room or kitchen. Residents can't eat in the dining room because it's too hot. They should be able to eat in the dining room. During an interview on 6/22/22 at 9:33 A.M., [NAME] K said there hasn't been air conditioning in the kitchen or dining room for months. He/she was not sure if someone has been out to inspect the issue. It's too hot for the residents to eat in the dining room safely. The residents should be able to enjoy their home and eat in the dining room. Pipes keep backing up and leaking throughout the facility. There is a trash can at the end of the hall on the first floor that is filled with water and trash and it looks terrible. The trash can has been like that for days. During an interview on 6/22/22 at 10:07 A.M., CMT L said the first floor dining room has been shut down for weeks because it is too hot for residents to eat in there. Residents should be able to eat in the dining room. Right now, they are eating in their rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. During an interview on 6/22/22 at 12:21 P.M., the Assistant Director of Nursing (ADON) said the dining room on the first floor is not in use because it is so hot. Residents are eating in their rooms because it is too hot for them to eat safely in the dining room. The air conditioning in the dining room is broken. It is not considered homelike for residents to be eating in their rooms and they should have a separate space where they can eat. There are plumbing issues all over the building. Trash cans get put underneath leaking pipes and it doesn't look homelike or sanitary. Many of the residents at the facility have diagnoses requiring more frequent redirection and supervision to ensure they remain in safe areas. 15. During an interview on 6/21/22 at 1:41 P.M., the Maintenance Director said the areas where ceiling tiles are missing are where there have been issues with leaking pipes. The pipes in the facility are old and some are corrosive. There have been ongoing issues with leaks and sewage. Maintenance staff addresses problems with the plumbing as they arise and move residents to different rooms if they cannot resolve the issue. The city sewer district inspected the facility and they are investigating one of the sewer lines in front of the building. The facility has had one plumbing company inspect the building and they provided an estimate for repairs. The facility is reaching out to other plumbing companies for additional inspections. The facility has had an ongoing issue with pests, including mice. Previous maintenance staff was not doing treatments and current maintenance staff tries to address issues as they arise. There was a miscommunication and the pest control company missed the last two applications. The contract with the pest control company has been updated so going forward, they will treat outside the facility once a month and inside the facility twice a month. Facility staff do their part by finding food in resident rooms and storing it better. During an interview on 6/22/22 at 11:31 A.M., the Maintenance Director said today, he was made aware the trash can at the end of the hall on the first floor was full of water and trash. The water should be emptied daily, but this is an accumulation of several days. All staff, including housekeeping, maintenance, and dietary, should share the responsibility of emptying the trash can. He expected staff to notify him sooner if they had issues with emptying the can filled with water. Trash cans filled with garbage and water is not considered homelike. He was not aware residents have been unable to eat in the first floor dining room for the past two weeks. Today, staff made him aware there was an issue with the air conditioning in the dining room and kitchen. He expected staff to notify him of this sooner. He looked at the thermostat in the dining room and kitchen, and found someone turned on the heat in both areas. It is unknown when this occurred. He made adjustments and the air conditioning should turn on in the dining room. It is not considered homelike for residents to have to eat in their rooms. Residents should have a choice where they eat. He will order industrial sized fans to help cool the dining room. Observation with the Maintenance Director on 6/22/22 at 12:01 P.M., showed the first floor dining room thermostat set to cool at a temperature of 71 degrees Fahrenheit (F). The current temperature showed 88 degrees F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16. During an interview on 6/21/22 at 10:37 A.M., the administrator said he began his position with the facility on 5/12/22. The facility has identified issues related to plumbing and sewage. There are plumbing leaks everywhere, some of which are easy to diagnose and others that are not. The plumbing issues in the activity room came from above and below the room. When there are issues in resident rooms, the residents are moved immediately. The facility has obtained a bid from one plumbing company and the recommended repairs are prohibitively expensive. A second opinion will be obtained from another company. Last week, he found out there were routine inspections for pest control which were not being done. The pest control company did not come out in May 2022 and their first return visit to the facility took place on 6/15/22. The new plan is for the pest control company to treat the facility three times a month. Pest control documentation was provided. Review of the facility's pest control logs from May and June 2022, showed: -A service log, dated 6/15/22; -No further documentation of pest control services provided during this timeframe. During an interview on 6/22/22 at 1:02 P.M., the administrator said in regard to missing ceiling tiles and leaking pipes throughout the facility, he expected staff to solve problems as best as possible. He expected staff to empty trash cans below leaking pipes when they are full, or to let someone else know so they can address the issue. Maintenance or housekeeping staff would be responsible for maintaining trash cans below leaking pipes, but if the issue is noted by staff of other disciplines, they should empty it or report it. He is aware there is a temperature issue in the first floor dining room due to the heating, ventilation, and air conditioning (HVAC) system. During the past two weeks, he observed residents eating breakfast in the dining room on one or more occasions. He was not aware staff were not allowing residents to eat in the dining room during the past two weeks. Prohibiting residents from eating in the dining room is a decision to be made by the administrator. He expected residents to be able to eat in the dining room. MO00201380 MO00201748 MO00201901 MO00202759 MO00202769

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to follow their policy and report allegations of resident abuse to the Department of Health and Senior Services (DHSS) as required, within a two-hour time frame, when one resident (Resident #812) displayed aggressive behaviors towards other residents (Resident #814, #802, Resident #813 and Resident #801). The sample was 13. The census was 119. Review of the facility's Abuse Investigation and Reporting policy, revised 7/2017, included: -All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported; -Reporting: -All alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies: -The State licensing/certification agency responsible for surveying/licensing the facility; -The resident's representative of record; -Law enforcement officials; -the resident's attending physician; -An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: -Two hours if the alleged violation involved abuse OR has resulted in serious bodily injury; -Twenty-four hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 1. Review of Resident #812's most recent quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/28/22, showed: -Adequate vision and hearing; -Resident understood and understands others; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -No behaviors including hallucinations or delusions exhibited; -No behaviors including physical or verbal toward others exhibited; -No rejection of care exhibited; -Diagnoses include paranoid Schizophrenia (a serious mental disorder in which people interpret reality abnormally), hallucinations, psychotic disorder with delusions (severe mental disorders that cause abnormal thinking and perceptions) , impulsiveness, restlessness and agitation. Review of the resident's progress notes, showed the following: -On 8/13/22 at 5:59 P.M., the resident walked the hall. He/she took an object off the wall and hit another resident (Resident #814). Staff notified the resident's physician and placed the resident on 15 minute checks. At 10:46 P.M., the resident continued to walk back and forth. Staff sent the resident to the hospital; -On 9/8/22 at 2:23 P.M., staff witnessed the resident and another resident (Resident #815) hitting each other while standing in the hall while waiting to be taken down to activities. Both residents were separated. The resident was easily separated and walked to room to deescalate situation. Staff continued to monitor the residents during their shift. Staff notified the Director of Nursing (DON) and resident's physician. At 2:24 P.M. , the resident was alert and disoriented. He/she was unable to make his/her needs known. He/she paced back and forth down the hallway most of the shift and when staff asked a question, he/she just walked off; -On 9/10/22 at 2:00 P.M., staff informed the nurse, the resident hit Resident #802 on the right arm. Staff heard Resident #802 say Resident #812 just hit him/her but did not witness it. Resident #812 continued to ambulate down the hall and the staff member heard Resident #813 yell he/she better come get Resident #812 as he/she had just hit him/her in the face. Staff attempted to separate the residents at that time. Resident #812 asked the staff member why did he/she tell his/her mother to not cook him/her some chicken cacciatore and then hit the staff member in his/her left eye and then jumped back and asked the staff member if he/she wanted to fight. At 2:15 P.M., staff called an ambulance company to transfer the resident to the hospital for a psychological evaluation related to aggression and combativeness; -On 9/11/22 at 2:48 A.M., the resident returned to the facility. Shortly after arrival, the resident paced in and out of his/her room and down the hallway. Staff placed a call to the resident's physician. At 10:00 A.M., a staff member said the resident punched him/her in the side of the face as he/she was passing out medication. At 10:44 A.M., staff reported the resident struck the certified medication technician (CMT) in the face while he/she prepared medication with his/her back turned to the resident. Staff observed the resident pacing up and down the hallway. All attempts to redirect the resident were unsuccessful. Other residents overheard staff expressing being afraid of what the resident might do to them because of recent incidents. Staff were instructed to try and remain between Resident #812 and other residents to possibly minimize triggers and avoid possible physical altercations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan dated 9/13/22, showed the following: -Focus: Alleged resident to resident altercation towards two residents. Resident is combative, hitting and spitting at staff. 9/13/22, continues behaviors toward others; -Goal: No further aggression and combativeness through next review; -Interventions: 9/10/22 - Resident sent to hospital for psychiatric evaluation. 9/11/22 - Resident sent to hospital related to behaviors towards staff. Resident on frequent checks. Separate from other residents at the time; -Focus: Resident has episodes of aggressive behavior towards others at times. The resident has visual and auditory hallucinations. 8/13/22, the resident struck a resident in the face with a butterfly ornament. 9/7/22, the resident readmitted to the center with new medication orders. 9/11/22, new orders for Haldol (a medication used to treat psychotic disorders- conditions that cause difficulty telling the difference between things or ideas that are real and things or ideas that are not real) by mouth or IM (intramuscular injection injection) as needed; -Goal: The resident will have fewer episodes of aggressive behavior; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Determine if the behavior poses danger to the resident or others. Anticipate and meet the resident's needs. Assign consistent caregivers. Provide safe, quiet, low-stimuli environment. Maintain consistent routine. Discourage resident from acting on feelings and impulses. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Physician and responsible party made aware of health status. Praise any indication of the resident's progress/improvement in behavior. Reward the resident for appropriate behavior. Review of a daily nursing report dated 9/13/22, showed the following: -3-11 shift; -Discharges: Resident #812 at hospital for behavior; -Behaviors/Interventions: The resident fighting and punched Resident #801 in the chest. The resident fist fighting Resident #802. Further review of the resident's progress notes, showed for 9/13/22, no documentation of resident being sent back to hospital. No documentation of altercations involving resident. 2. Review of Resident #800's admission MDS dated [DATE], showed the following: -Adequate hearing and vision; -Able to understand others and be understood; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact. Review of the resident's progress notes, showed on 9/13/22 at 5:03 P.M., This nurse and Assistant Director of Nursing (ADON) on the floor addressing an unrelated situation when the resident was observed going to coax Resident #812 from the dining room several times. When Resident #812 would sit down to calm him/herself this resident would coax him/her from the dining room. This resident then waited for this nurse and ADON to step toward the door and he/she screamed. This nurse then observed the resident on the floor 15 feet away. The resident stated that Resident #812 hit him/her in the mouth. Resident #812 was two feet from this nurse at the time the resident ended up on the floor. The resident then stated that Resident #812 tripped him/her. The resident was complaining of right arm pain. The resident was assessed, the MD was called awaiting return call. X-ray vendor to be called for x-ray. During an interview on 9/14/22 at 9:30 A.M., and 1:28 P.M., Resident #800 said Resident #812 hit two other residents the day before and he/she had to pull the resident off the second resident. Staff did not intervene until after he/she pulled the residents apart. Resident #812 hit other residents prior to this and the other residents were scared of him/her. He/she went into other resident's rooms and tried to take their things and then hit them if they confronted him/her. There was not enough staff on duty to watch him/her all the time and he/she was getting worse. They had sent him/her to the hospital a few times but he/she kept coming back. At approximately 4:30 P.M. the previous day, he/she was tripped another resident and hit his/her head and shoulder. The resident had a golf ball sized swollen area with bruising on his/her right cheek and his/her right arm appeared reddish and swollen. The resident's shoulder appeared out of place. 3. Review of Resident #802's annual MDS dated [DATE], showed the following: -Adequate hearing and vision; -Able to understand others and be understood; -Cognitively intact. During an observation and interview on 9/14/22 at 9:35 A.M., Resident #802 had slight bruising on the left side of his/her face under his/her eye and a 1.5 inch scratch on his/her right chest below his/her shoulder. He/she said yesterday Resident #812 came into his/her room and punched him/her on the left side of his/her face. He/she then punched the resident back and another resident had to pull them apart. Then the staff sent Resident #812 to the hospital. He/she was not afraid of the other resident but he/she was going to fight back because staff will not intervene. Staff are afraid of him/her. They had a staff member walk out of the facility after the resident hit him/her. 4. During an interview on 9/14/22 at 10:00 A.M., CMT E said on 9/10/22 around 11:00 A.M., Resident #802 told him/her Resident #812 hit him/her on the arm. While he/she was assessing the resident, he/she heard Resident #813 yell out Resident #812 had hit him/her in the head. The CMT did not feel safe working with the resident and did not feel he/she could keep the other residents safe from him/her. 5. Review of DHSS' system for reporting alleged violations, showed no facility self-report regarding the incidents on 8/13/22, 9/8/22, 9/10/22 or 9/13/22. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. During an interview on 9/15/22 at 7:19 A.M., ADON A said she does not report allegations of abuse or neglect in her role. She collects statements from staff and residents and informs the DON and administrator of her findings. She said the types of abuse included verbal, physical and mental abuse. The resident hitting other residents was not abuse because the resident wasn't aware of what she was doing due to psychiatric issues. 7. During an interview on 9/14/22 at 4:33 P.M. and 9/15/22 at 2:09 P.M., the corporate nurse said there was a two hour window to call in allegations of abuse. She liked to get the facts first to see if it was behavioral issue rather than abuse. There are some altercations that would not be reported. She was aware the resident had hit staff over the weekend, but was unaware the resident had also hit residents. She would expect staff to notify the administrator of allegations of abuse and for an investigation to be started. They would then determine if DHSS should be notified. This should happen within the two hour timeframe. These incidents were not reported due the investigation findings showed the resident's actions were behavioral and not abuse. There were no injuries, residents felt safe and were not threatened. The resident did not have the intent to abuse. He/she doesn't remember doing these because it was behavioral. They have called similar issues in before and felt like they were told to it wasn't abuse and to keep a soft file.

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	06/22/2022

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

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #800) received prompt treatment and care after the resident fell and dislocated his/her shoulder. Facility staff failed to obtain an in-house x-ray ordered by the resident's physician in a timely manner or obtain further evaluation and treatment timely when the resident complained of pain and his/her shoulder was assessed by nursing staff as having deformity with redness to right shoulder with swelling to entire arm. The sample was 13. The census was 119. Review of the facility's Discharging a Resident Without a Physician's Approval policy, revised 10/2012, showed: -A physician's order should be obtained for all discharges, unless a resident or representative is discharging himself/herself against medical advice; -Policy interpretation and implementation: -Should a resident or his/her representative, request an immediate discharge, the resident's attending physician will be promptly notified; -The order for an approved discharge must be signed and dated by a physician and recorded in the resident's medical record no later than 72 hours after the discharge; -If the resident or representative insists upon being discharged without the approval of the attending physician, the resident and/or representative must sign a Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members. -The policy did not state if a resident called 911 for medical assistance, this would result in leaving AMA without the option to return to the facility. Review of Resident #800's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/21/22, showed: -admitted on [DATE]; -Adequate vision and hearing; -Resident understood and understands others; -Cognitively intact; -No mood issues; -No behavior exhibited; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-No rejection of care exhibited; -Pain management: On a scheduled medicine regimen - Received as needed (PRN) pain meds in last five days; -Recent surgery requiring active skilled nursing facility care: Yes; -Surgical procedures: Repair fractures of the shoulder. Review of a daily nursing report, dated 9/13/22, included the following: -3-11 shift; -Behaviors/Interventions: Resident #812 tripped Resident #800 onto the floor with a dislocated shoulder. Review of the resident's progress notes, showed the following: -On 9/13/22 at 5:03 P.M., this nurse and Assistant Director of Nursing (ADON) on the floor addressing an unrelated situation when the resident screamed. The nurse observed the resident on the floor 15 feet away. The resident stated Resident #812 hit him/her in the mouth. The resident then stated Resident #812 tripped him/her. The resident complained of right arm pain. The resident was assessed, the MD was called awaiting return call. X-ray vendor to be called for x-ray; -At 5:08 P.M., the resident's weekly skin observations showed skin color was other, refer to assessment for more information. No swelling or broken skin noted; -At 5:18 P.M., staff alerted the nurse the resident was on the floor complaining of pain to his/her right shoulder. He/she stated he/she was tripped and hit the floor. Skin assessment completed. Call placed to physician for notification and next steps. Staff awaiting return call; -At 5:40 P.M., the ADON gave report to the nurse. The resident stated he/she wanted to go to the hospital for right arm pain. Staff made the resident aware they were waiting for the physician to call back. Staff explained they could not send him/her out without a physician's order. The resident told staff he/she would call EMS himself/herself. Staff explained he/she had the right to do so, but it would be going against medical advice; -On 9/14/22 at 7:41 A.M., the resident complained of right arm/shoulder and facial pain related to fall. Resident has raised area, redness and swelling to right cheek and deformity with redness to right shoulder with swelling to entire arm. Call placed to x-ray vendor for right shoulder, humerus (a long bone located in the upper arm, between the shoulder joint and elbow joint), elbow, forearm and facial bones. Ordered STAT. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During observation and interview on 9/14/22 at 9:30 A.M., and at 1:28 P.M., the resident said at approximately 4:30 P.M. the previous day, he/she was tripped by another resident and hit his/her head and shoulder. Staff told the resident he/she would get an x-ray the day before, but he/she still had not gotten one. The pain was getting worse. He/she wanted to go to the hospital, but staff told him/her no. He/she was going to call 911 and have them take him/her to the hospital, but the staff told him/her if he/she did this, they would make him/her sign a paper saying he/she was doing this AMA and kick him/her out of the facility. When the resident called 911, he/she was told a nurse would need to call on his/her behalf. Around 8:00 P.M., when other nurses came to the unit, they said the resident needed to go out, but were told if he/she left it would be AMA. Staff tried to reach the doctor several times, but he was not calling back. Last night, the resident called EMS and the police arrived at the facility. He/she tried to talk to them and showed the police his/her arm. A nurse intervened and said he/she was canceling the EMS request because they were awaiting an x-ray. The police left and the resident could not make a report. The resident said his/her pain was at an 8 or 9 on a scale of 1-10 (0 indicating no pain and 10 indicating worst pain ever felt). He/she cried all night. When he/she moved his/her shoulder, it made a clicking sound. It hurt for the resident to blink. The resident had a golf ball sized swollen area with bruising on his/her right cheek and his/her right arm appeared reddish and swollen. The resident's shoulder appeared out of place. Observation on 9/14/22 at 1:43 P.M., showed two EMS representatives and Nurse K walked into the resident's room. The resident showed the EMS representatives his/her shoulder. An EMS representative said the resident's shoulder was dislocated. During an interview on 9/14/22 at 1:50 P.M., Nurse K said the resident hadn't been at the facility very long. Nurse K said it was not his/her call to send the resident out earlier, but he/she believes the resident should have been sent out last evening after he/she injured his/her shoulder. The resident's shoulder appeared to be dislocated. During an interview on 9/14/22 at 3:41 P.M., the Director of Nursing (DON) said she did not witness the resident injuring his/her shoulder. Resident #812 was ahead of Resident #800 when the DON walked down the hall on 9/13/22 to leave the unit. She turned her back to the residents to enter the code for the door and heard Resident #800 scream and was on the floor. Resident #800 said Resident #812 hit him/her in the mouth and tripped him/her. ADON B said he/she was going to handle the situation so the DON left the unit. She did not see the resident again because she left the building shortly thereafter. ADON B called the physician's exchange three times because this occurred after hours and did not receive a call back. The DON called the resident's doctor directly twice and it went straight to voicemail. The resident said if he/she wasn't sent to the hospital, he/she would call 911 himself/herself. There was a previous discussion that the resident has the right to call 911. The facility must have a doctor's order before a resident can be sent to the hospital. If a resident went to the hospital without an order, they would be going AMA. The DON was not aware the resident called 911. The resident's doctor did not call back until this morning. ADON B offered to make the resident comfortable while they waited for orders, but the resident was adamant he/she wanted to go to the hospital. The facility took action by getting an x-ray. If a resident's shoulder was dislocated, she would expect they would need more medical attention than what could be provided at the facility. Her understanding was that a confirmation of a dislocated shoulder was needed before the resident could be sent out. This directive came from above her. The DON agreed the resident waited a long time before he/she received treatment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/14/22 at 3:20 P.M., ADON B said he/she and the DON were up on the floor just prior to the resident falling. They had just left the unit when they heard a cry and looked through the window and saw the resident on the floor. They immediately went back in to see what happened. The resident claimed another resident had tripped him/her causing him/her to fall. When he/she entered the unit, the resident was on the floor grimacing and when asked what happened he/she said Resident #812 had tripped him/her. The ADON assessed him/her and thought something was wrong with his/her arm. It was red and did not move right. The resident was talking okay and did not complain of pain to him/her. The nurse ordered an x-ray and notified the resident's physician and family. The nurse did not put the x-ray in as STAT. When he/she left at 6:30 P.M., the x-ray company had still not responded. They did not send him/her to the hospital because they needed a physician's order to do this and his/her hands were tied because the physician had not called back. They should have called him/her or the physician again if the resident complained of increased pain. When the ADON came back to work on 9/14/22, he/she found out the x-ray company never showed up. They called the x-ray company who said they never got the order. To his/her knowledge, the resident was told he/she would be AMA if he/she called 911 and went to the hospital. At the facility, residents cannot call 911 or go to the hospital on their own. Medically, they have to go through a physician or a nurse. During an interview on 9/14/22 at 4:08 P.M., Certified Medication Technician (CMT) D said he/she was working the floor the prior evening when the resident fell . He/she did not see the resident actually fall, but heard him/her cry out. The CMT was at the desk and the resident was down closer to the dining room. He/she saw the resident on the floor. The resident said Resident #812 stuck out his/her foot and tripped him/her causing him/her to fall to the floor. The resident complained of pain in his/her shoulder and said it was dislocated. The arm did not look normal. It looked like something was sticking out of his/her skin. At that point ADON B and the DON came into the unit and assessed the resident. The CMT did not know what the resident told them, as he/she left the resident at that point. The resident continued to complain of pain and held his/her arm through the night. The CMT gave him/her some extra strength Tylenol, as that is all they were allowed to give him/her per his/her physician's orders. The nurse on duty mentioned he/she wondered when the x-ray vendor was going to come and passed the information onto the oncoming shift. During an interview on 9/14/22 at 4:30 P.M., the corporate nurse said it is not the facility's policy to discharge residents AMA if they call 911. He/she said the resident has a history of dislocating his/her shoulder. He/she had an accident prior to coming to the facility and never got it fixed. She would have expected staff to call the x-ray company back if they had not shown up. Sometimes they had a problem with the x-ray company coming out after hours due to the area. The DON called her around 6:00 P.M., and told her the resident had fallen, the physician had been called and gave an order for an x-ray. The physician told the staff not to send the resident out until the arm was x-rayed. She told staff they needed to follow physician's orders and her understanding was he said do not send him/her out. Review of the resident's care plan, dated 9/14/22, showed the following: -Focus: Resident complained of right arm/shoulder and facial pain related to fall. Resident has raised area, redness and swelling to right cheek and deformity with redness to right shoulder with swelling to entire arm. Call placed to x-ray company for right shoulder, humerus, elbow, forearm and facial bones. Ordered STAT (immediately). Staff report resident stated another resident tripped him/her; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Goal: Resident will not have severe injuries/abuse through next review; -Interventions: Call placed to x-ray company for right shoulder, humerus, elbow, forearm and facial bones. Assess for pain/injuries. Give pain medication as needed. Inform administration/Director of Nursing (DON)/Assistant DON about incident/resident's status; -Focus: Resident is at risk for falls related to antidepressant medications; -Goal: The resident will be free of injury related to falls; -Interventions: Anticipate and meet the resident's needs as needed. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Resident ambulates independently; -Review of the care plan on 9/14/22 at 2:21 PM, showed it did not contain a focus area of the resident purposely dislocating his/her right shoulder for attention and wanting to go to the hospital. Review of the resident's hospital records, dated 9/15/22, showed the following: Hospital note included: Currently the patient's complaining of pain in the right shoulder, the pain is sharp, moderate, worse with movement, no radiation, patient denies LOC (loss of consciousness); -Physical exam: Right cheek erythema (superficial reddening of the skin, usually in patches, as a result of injury or irritation). Right shoulder ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising with deformity), tender to touch, range of motion limited by pain, right forearm below elbow ecchymosis; -A radiology report dated 9/14/22, with findings of the humeral head (the top of the humerus - upper arm bone) is anteriorly (an anterior shoulder dislocation is an injury in which the bone of the upper arm, called the humerus, is dislocated from the shoulder joint), and inferiorly (a condition in which the head of the humerus is detached from the shoulder joint). No visible fracture. Facial bones: No acute osseous abnormality demonstrated; -Progress notes showed on 9/14/22 at 4:36 P.M., the resident's right shoulder was reduced back. During an interview on 9/15/22 at 6:30 A.M., Nurse C said he/she worked overnight on 9/14/22. No one told him/her the resident fell when he/she arrived to work. The resident dislocated his/her shoulder previously on a different floor and they thought he/she was trying to get out of the facility. The nurse on duty on the resident's floor called over on the night in question and asked him/her what he/she should do about the resident. He/she told the other nurse to send him/her to the hospital if he/she was complaining about pain. That nurse wanted to send the resident out, but had been given instructions to not send out until orders were received. Facility administration wants nurses to contact the doctor and notify the DON and ADON before sending residents out. If the resident complained of pain and only had Tylenol, he/she would send the resident out because an x-ray could be obtained at the hospital. The staff were waiting for the resident's physician to come see him/her the next day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/15/22 at 7:20 A.M., ADON A said he/she had already left for the day when the resident fell . Staff contacted him/her that evening to say the resident had fallen and they thought his/her shoulder was dislocated. He/she thought the ADON and DON had taken care of it since they were still there when it happened. If the resident fell , he/she would assess that resident, call the physician, ask for an x-ray and if the arm was visibly dislocated, would have sent him/her out to the hospital. He/she would use his/her nursing judgement. As a nurse, had he/she been there, he/she would have sent him/her out. During an interview on 9/15/22 at 8:06 A.M., Staffing Coordinator L said he/she was told there was a resident to resident altercation and Resident #800 was brought downstairs to defuse the situation. When he/she saw the resident he/she thought the resident should go to the hospital. Staffing Coordinator L called up to the unit and was told by ADON B the resident was known to pop his/her shoulder out of place and wasn't going to be sent to the hospital. The resident said he/she was in a lot of pain and needed to go to the hospital. The resident's arm looked red was turning purple and the resident was holding it. During an interview on 9/15/22 at 11:10 A.M., Nurse F said staff told him/her the resident was tripped by another resident and fell on [DATE]. The evening nurse already called for an x-ray. On 9/14/22 when he/she found out the x-ray had not been done, he/she attempted to call two x-ray companies the facility used and neither one had an order for the x-ray. When he/she assessed the resident that night, his/her arm was swollen. He/she tried to call the resident's physician again, but got the exchange. They said the physician would not be available until 7:00 A.M., so he/she left a message. At 7:00 A.M., he/she attempted to call the physician again and the person who answered said the physician was out at another facility and would not be able to be reached until 9:00 A.M., but they would send him a text. The physician texted him/her at 7:35 A.M., after he/she left for the day and said he/she called the facility and ordered an x-ray STAT. He/she waited to get an order from the physician because he/she would never send a resident to the hospital without a physician's order. During an interview on 9/15/22 at 9:03 A.M., the social worker for the resident's physician said the physician attempted to call the facility back four to five times on 9/13/22, but was unable to reach anyone. An order for an x-ray was given on 9/14/22 at 8:10 A.M. An order to send the resident to the hospital was given at 1:14 P.M. on 9/14/22. During an interview with the administrator and corporate nurse on 9/15/22 at 2:09 P.M., the corporate nurse residents have the right to go to the hospital if they want, but EMS has said they will not transport just because a resident wants to go. Review of the facility's investigation, provided to DHSS on 9/15/22 and completed by the corporate nurse, included the following: -Resident will purposefully dislocate his/her shoulder in an attempt to seek attention and go to the hospital due to drug seeking behaviors. Resident will also refuse treatment at times; -On 9/13/22 at approximately 5:05 P.M., the resident stated another resident hit him/her in the mouth. The resident then stated the other resident tripped him/her; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Upon assessment the resident complained of right arm pain. Arm was assessed and range of motion was within normal limits. Upon inspection, there was not any abnormalities of the right arm or shoulder. The physician was called and orders were placed for an x-ray; -On 9/13/22 at approximately 5:40 P.M., the resident stated he/she wanted to go to the hospital for right arm pain. Resident was informed the physician was called and an order was needed to send the resident to the hospital; -The doctor did not order the resident to be sent to the hospital; -Call placed to resident's physician to discuss concerns about resident's incident on 9/13/22. The physician said he was aware the resident had an incident involving his/her right shoulder. The physician said he gave the order to obtain an x-ray in house rather than sending the resident immediately to the hospital; -This was because someone with chronic dislocation like the resident does not need to be immediately sent. It is more cost effective and better for the resident to obtain in house mobile x-ray company unless it is obvious the resident is going to need medical attention; -Conclusion: No order was given by the physician to send resident to the hospital, orders were obtained for x-ray in the A.M. MO00207024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to protect residents (Resident #802, Resident #813 and Resident #801) from one resident (Resident #812) who displayed behaviors of physical aggression. The census was 119. 1. Review of Resident #812's most recent quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/28/22, showed: -admitted on [DATE]; -Adequate vision and hearing; -Resident understood and understands others; -Cognitively intact; -No behaviors including hallucinations or delusions exhibited; -No behaviors including physical or verbal toward others exhibited; -No rejection of care exhibited; -Diagnoses include paranoid Schizophrenia (a serious mental disorder in which people interpret reality abnormally), hallucinations, psychotic disorder with delusions (severe mental disorders that cause abnormal thinking and perceptions) , impulsiveness, restlessness and agitation. Review of the resident's progress notes, showed the following: -On 8/13/22 at 5:59 P.M., the resident walked the hall. He/she took an object off the wall and hit another resident. Staff notified the resident's physician and placed the resident on 15 minute checks. At 10:46 P.M., the resident continued to walk back and forth. Staff sent the resident to the hospital; -On 9/7/22 at 5:22 P.M., the resident returned from the hospital at 4:45 P.M. Staff called the resident's physician to review the medication list. The resident displayed anxious and wandering behavior. There were new orders for medication; -On 9/8/22 at 2:23 P.M., staff witnessed the resident and another resident hitting each other while standing in the hall while waiting to be taken down to activities. Both residents were separated. The resident was easily separated and walked to room to deescalate situation. Staff continued to monitor the residents during their shift. Staff notified the Director of Nursing (DON) and resident's physician. At 2:24 P.M., the resident was alert and disoriented. He/she was unable to make his/her needs known. He/she paced back and forth down the hallway most of the shift and when staff asked a question, he/she just walked off; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 9/10/22 at 2:00 P.M., staff informed the nurse, the resident hit Resident #802 on the right arm. Staff heard Resident #802 say Resident #812 just hit him/her but did not witness it. Resident #812 continued to ambulate down the hall and the staff member heard Resident #813 yell he/she better come get Resident #812 as he/she had just hit him/her in the face. Staff attempted to separate the residents at that time. Resident #812 asked the staff member why did he/she tell his/her mother to not cook him/her some chicken cacciatore and then hit the staff member in his/her left eye and then jumped back and asked the staff member if he/she wanted to fight. At 2:15 P.M., staff called an ambulance company to transfer the resident to the hospital for a psychological evaluation related to aggression and combativeness. The estimated time of arrival was two hours. Staff escorted the resident off the unit away from other residents and staff. At 2:30 P. M., staff texted the resident's physician who gave orders to send the resident to the hospital for an evaluation. At 3:20 P.M., the resident was sent to the hospital; -On 9/11/22 at 2:48 A.M., the resident returned to the facility. Shortly after arrival, the resident paced in and out of his/her room and down the hallway. Staff placed a call to the resident's physician. At 10:00 A.M., a staff member said the resident punched him/her in the side of the face as he/she was passing out medication. At 10:20 A.M., the resident was escorted off the unit and to the nursing office. At 10:35 A.M., staff called the hospital and someone from intake told the staff member, the resident could be seen in the emergency room , consult with a physician and once stabilized would be sent back to the facility due to no bed being available. Staff called another hospital and someone from intake said since the resident was sent to their hospital before and was nonverbal at that time, the facility would need an affidavit from the resident's guardian to be treated. At 10:44 A.M., staff reported the resident struck the certified medication technician (CMT) in the face while he/she prepared medication with his/her back turned to the resident. Staff observed the resident pacing up and down the hallway. All attempts to redirect the resident were unsuccessful. Other residents overheard staff expressing being afraid of what the resident might do to them because of recent incidents. Staff were instructed to try and remain between Resident #812 and other residents to possibly minimize triggers and avoid possible physical altercations. Staff notified the resident's physician who gave orders to send to the hospital for further evaluation. Staff placed a call to the ambulance company and were awaiting pick-up. At 10:59 A.M., staff called another hospital to see if they could take the resident. They said they could take the resident. Staff waited for the ambulance transport. The resident remained off the unit and continued to wander in the office touching things with no combativeness noted. At 11:38 A.M., staff attempted to call the psychiatric nurse but there was no answer. At 11:39 A.M., staff texted the resident's physician to obtain an order. The physician gave a new order for Haldol Lactate (used to treat certain mental/mood disorders) 5 milligrams intramuscularly (given by needle into the muscle) or by mouth every 6 hours for agitation/psychosis as needed (PRN). At 3:08 P.M., staff called an ambulance company. Estimated time of arrival within the hour. At 4:00 P.M., the resident sent to the hospital for psych evaluation; -No documentation on when resident returned from the hospital; -On 9/12/22 at 12:22 P.M., the resident was calm and to self. Pacing halls. Staff continued to monitor during shift; -On 9/13/22 at 12:22 P.M., no behaviors observed. Review of the resident's care plan dated 9/13/22, showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Alleged resident to resident altercation towards two residents. Resident is combative, hitting and spitting at staff. 9/13/22, continues behaviors toward others; -Goal: No further aggression and combativeness through next review; -Interventions: 9/10/22 - Resident sent to hospital for psychiatric evaluation. 9/11/22 - Resident sent to hospital related to behaviors towards staff. Resident on frequent checks. Separate from other residents at the time; -Focus: Resident has episodes of aggressive behavior towards others at times. The resident has visual and auditory hallucinations. 8/13/22, the resident struck a resident in the face with a butterfly ornament. 9/7/22, the resident readmitted to the center with new medication orders. 9/11/22, new orders for Haldol by mouth or IM as needed; -Goal: The resident will have fewer episodes of aggressive behavior; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Determine if the behavior poses danger to the resident or others. Anticipate and meet the resident's needs. Assign consistent caregivers. Provide safe, quiet, low-stimuli environment. Maintain consistent routine. Discourage resident from acting on feelings and impulses. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Physician and responsible party made aware of health status. Praise any indication of the resident's progress/improvement in behavior. Reward the resident for appropriate behavior. Review of a daily nursing report dated 9/13/22, showed the following: -3-11 shift; -Discharges: Resident #812 at hospital for behavior; -Behaviors/Interventions: The resident fighting and punched Resident #801 in the chest. The resident fist fighting Resident #802. Further review of the resident's progress notes, showed the following: -On 9/13/22, no documentation of resident being sent back to hospital. No documentation of altercations involving resident; -On 9/14/22 at 2:18 A.M., staff called the hospital to inquire about the resident's status. Hospital staff were unable to assess the resident after several attempts and were waiting for the psychiatric doctor to come in and assess him/her. Review of the resident's social service quarterly assessment datef 9/12/22, showed the following: -Mental status: Alert; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Orientated to person and place; -No memory impairment; -Mental function varies daily: Yes; -Impaired judgement: Yes; -Mood state: Patient always seems okay other than when doing wrong; -Wanders: No; -Demanding: Yes; -Poor impulse control: No; -Destruction of property: No; -Rejection of care: No; -Behavioral description: Goes in and out of others rooms taking their things that do not belong to him/her. Tries to hit others; -Social service required: No, will be provided as needed; -Discharge plan comments: Currently looking for another facility; -Care plan: No changes needed at this time. 2. Review of Resident #412's annual MDS dated [DATE], showed the following: -Adequate hearing and vision; -Able to understand others and be understood; -Cognitively intact. During an interview on 9/14/22 at 9:15 A.M., Resident #412 said Resident #812 and Resident #802 got into a fight the day before. Resident #812 went into Resident #802's room and hit him/her in the face and then Resident #802 hit him/her back. Resident #812 kept going around and punching on people. The staff sent him/her out to the hospital several times but he/she kept coming back and it was getting worse. Staff moved Resident #812 out of his/her room because he/she kept hitting his/her roommate in the head. All of the residents were afraid of him/her and some of the staff were too. You never knew when he/she was going to go off and punch you. Staff could not keep them safe because they could not be everywhere. 3. Review of Resident #800's admission MDS dated [DATE], showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Adequate hearing and vision; -Able to understand others and be understood; -Cognitively intact. During an interview on 9/14/22 at 9:30 A.M., Resident #800 said Resident #812 hit two other residents the day before and he/she had to pull the resident off the second resident. Staff did not intervene until after he/she pulled the residents apart. Resident #812 hit other residents prior to this and the other residents were scared of him/her. He/she went into other resident's rooms and tried to take their things and then hit them if they confronted him/her. There was not enough staff on duty to watch him/her all the time and he/she was getting worse. They had sent him/her to the hospital a few times but he/she kept coming back. 4. Review of Resident #802's annual MDS dated [DATE], showed the following: -Adequate hearing and vision; -Able to understand others and be understood; -Cognitively intact. During an observation and interview on 9/14/22 at 9:35 A.M., Resident #802 had slight bruising on the left side of his/her face under his/her eye and a 1.5 inch scratch on his/her right chest below his/her shoulder. He/she said yesterday Resident #812 came into his/her room and punched him/her on the left side of his/her face. He/she then punched the resident back and another resident had to pull them apart. Then the staff sent Resident #812 to the hospital. He/she was not afraid of the other resident but he/she was going to fight back because staff will not intervene. Staff are afraid of him/her. They had a staff member walk out of the facility after the resident hit him/her. 5. During an interview on 9/14/22 at 10:00 A.M., CMT E said on 9/10/22 around 11:00 A.M., Resident #802 told him/her Resident #812 hit him/her on the arm. While he/she was assessing the resident, he/she heard Resident #813 yell out Resident #812 had hit him/her in the head. The CMT called for a nurse to come up and assess the residents but no one showed up for over two hours. He/she sat with Resident #812 until he/she calmed down. A short time after the nurse came up, CMT E was walking up the hall to finish passing out medications. Resident #812 came up behind him/her and hit CMT E in the face. They sent the resident out to the hospital after CMT E was hit but did not tell staff what to do when the resident came back. The CMT did not feel safe working with the resident and did not feel he/she could keep the other residents safe from him/her. 6. During an interview on 9/14/22 at 1:57 P.M., Nurse K said he/she was with an agency, but was familiar with Resident #812. Everyone was fearful of the resident which included staff and residents. The resident would hit someone, be sent out to the hospital, and then be sent right back to the facility. Nurse K was not aware of any new interventions for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. During an interview on 9/15/22 at 12:44 P. M., the facility's psychiatric nurse practitioner (NP) said she was trying to treat the resident's increased aggression with medication changes. This had to be done slowly. The resident's behaviors were unpredictable and everything seemed to irritate him/her. It had been difficult to stabilize the resident. The NP was concerned with the resident's increased behaviors and that he/she might hurt himself/herself. The resident looked feeble, but was strong. You could not tell what the resident's internal thoughts were. She did not know anything about what occurred over the weekend until recently, but here we are. He/she was in the hospital. The NP said she felt some residents on the unit antagonized Resident #812 until he/she became aggressive. Staff should ensure those residents were kept separated. 12. During an interview on 9/15/22 at 2:09 P.M. with the administrator and the corporate nurse who said the resident did not have the capacity to know what he/she was doing. The corporate nurse had never had a conversation with the resident where the resident could answer correctly. He/she was nonsensical in his/her responses. Staff did 1:1with the resident over the weekend before he/she went to the hospital. Staff had increased monitoring of the resident, but the resident also slept a lot. When the resident had increased pacing, staff should have known he/she was ramping up. The corporate nurse had been told by staff other residents followed Resident #812 around and antagonized him/her with little digs. Staff should intervene if they saw this occur.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40290 Based on observation, interview and record review, the facility failed to ensure pain management was provided consistent with professional standards of practice and the comprehensive care plan, by failing to ensure one resident (Resident #403) was provided with pain medication and a pain management referral as requested by the physician. The sample was 13. The census was 119. Review of the facility's undated Pain-Clinical Protocol, showed: -The physician and staff will identify individuals who have pain or who are at risk for having pain; -This includes reviewing known diagnosis and conditions that commonly cause pain; -It also includes a review for any treatments that the resident is receiving for pain, including complementary and non-pharmacologic; -The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain; -The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern and severity; -Staff will use consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level; -The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated: for example wound care, ambulation or repositioning; -The physician will order appropriate medication interventions to address the individual's pain; -For the individuals who is receiving opioid analgesics, the physician will order a regimen of laxatives and other measures to prevent constipation; -The staff will reassess the individual's pain at regular intervals for acute pain or significant changes in levels of chronic pain; -The staff will evaluate and report the resident's use of standing and PRN analgesics. Review of Resident #403's admission minimum data set (MDS), a federal mandated assessment instrument completed by facility staff, dated 4/7/22, showed: -Cognitively intact; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Extensive assistance required for bed mobility, transfer, dressing, toilet use and personal hygiene; -Pain management: -At any time in the last 5 days, has the resident been on a scheduled pain medication regimen: Yes; -Received PRN pain medications: Yes; -Received non-medication interventions for pain: No; -Pain interview: -Presence of pain: Yes; -Pain frequency: Frequently; -Had pain made it hard to sleep at night: Yes; -Have you limited your day-to-day activities because of pain: Yes; -Pain intensity: 10; -Diagnoses included anxiety disorder and hip fracture; -Care area assessment summary: Pain triggered as a care area and indicated as care planned by the facility. Review of the resident's care plan, dated 3/25/22, showed: -Focus: The resident had acute/chronic pain diagnosis with history of right femoral (the long bone of the thigh) nail (a metal rod that is inserted into the bone and across the fracture in order to provide a solid support for the fractured bone) fracture with right hip hemiarthropathy (a surgical procedure that involved replacing half of the hip joint) related to fall on 2/12/22, dislocated right hip. Date initiated 3/25/22; -Goal: Pain will be minimized with the use of scheduled and/or as needed pain medications; -Interventions: Administer analgesia as per orders/as needed. Anticipate the residents need for pain relief and respond immediately to any complaint of pain. Follow-up with pain management as ordered. Monitor/record/report to nurse resident complaints of pain or request for pain treatment. Review of the resident's admission pain assessment, dated 3/25/22, showed: -Should pain admission assessment be conducted? Yes; -Resident was alert and oriented to person, place and time; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Current pain level was a 10 out of 10 scale (0 equals no pain 10 equals the worse pain); -Had acute and chronic pain; -Pain will be minimized with the use of scheduled and/or as needed (PRN) pain medications; -Anticipate the residents need for pain relief and respond immediately to any complaints of pain; -Report to nurse resident's complaints of pain or request for pain medication. Review of the resident's electronic physician orders (ePOS), showed: -An order dated 3/25/22, for acetaminophen (Tylenol) 500 milligram (mg) every 6 hours as needed for moderate pain; -An order dated 3/25/22, for oxycodone HCL (narcotic pain medication 5 mg every 6 hours as needed; -An order dated 5/1//22, for tramadol HCl (an opiate analgesic used to treat moderate or severe pain) tablet 100 mg. Give 100 mg by mouth every 8 hours as needed for pain; start after oxycodone runs out. Review of the resident's progress notes, showed on 4/22/22 at 12:33 P.M., staff documented a call placed for pain management, but the office was closed. No further documented attempts to contact pain management. During an interview on 6/22/22 at approximately 1:00 P.M., the Assistant Director of Nursing (ADON) said the reason pain management was contacted was because of the residents reports of uncontrolled pain. Review of the resident's medical record, showed no documentation pain management was involved in the resident's care. Further review of the resident's ePOS, showed no order to follow-up with pain management. During an interview on 6/22/2022 at 2:00 P.M., Physician Representative M, the assistant for Physician N, said: -On 4/6/22, the physician wrote a script for oxycodone; -In May the physician wrote an order for tramadol 60 pills with 2 refills to start when oxycodone runs out and for pain management; -The physician would expect the resident to receive medications as ordered. Also, would expect to be notified if issues arise with medications; -Pharmacy calls the physician for medication issues. The pharmacy had not called the physician with concerns related to the resident's pain medications; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The physician ordered the facility to follow up with pain management. Review of the resident's May 2022 Medication Administration Record (MAR) showed: -An order for acetaminophen 500 mg every 6 hours as needed for moderate pain, dated 3/25/22: Documented as administered on 5/8/22 and on 5/14/22; -An order for oxycodone HCl tablet 5 mg. Give 5 mg by mouth every 6 hours as needed for pain start date, 3/25/2022: Documented as administered 5/1/22 and on 5/22/22; -An order for Tramadol HCl tablet 100 mg, give 100 mg by mouth every 8 hours as needed for pain, start after oxycodone runs out then discontinue oxycodone order, start date 5/1/22: Documented as administered 16 times during the month of May 2022. Review of the resident's June 2022 MAR, reviewed on 6/21/22, showed: -An order for acetaminophen 500 mg every 6 hours as needed for moderate pain, dated 3/25/22: Documented as administered on 6/4, 6/10, 6/11, and 6/15/22; -An order for oxycodone HCl tablet 5 mg. Give 5 mg by mouth every 6 hours as needed for pain start date, 3/25/2022: No documentation the medication administered for the month of June 2022; -An order for Tramadol HCl tablet 100 mg, give 100 mg by mouth every 8 hours as needed for pain, start after oxycodone runs out then discontinue oxycodone order, start date 5/1/22: No documentation the medication administered for the month of June 2022. Observation and interview on 6/21/22 at 10:45 A.M., showed the resident in bed, with his/her feet on top of a pillow. The resident said he/she can have Tylenol for pain control, but he/she has had an order for the pain medication tramadol, which was effective in controlling the pain. He/she was told the tramadol was unavailable. The Tylenol was not effective in controlling the pain. He/she had an order for oxycodone, but when it ran out the physician wrote an order for tramadol, which was administered in May, but then he/she was told it was unable to be reordered. The pain kept him/her from sleeping at night. The resident had facial grimacing during the interview. On 6/22/2022 at 9:50 A.M., he/she said that he/she asks every night for pain medication and only gets Tylenol, which was not effective. During an interview on 6/22/22 at 9:20 A.M., Certified Medication Technician (CMT) L said the resident had orders for oxycodone. When the medication ran out, the resident was to start tramadol for pain control. CMT L could not find any card of tramadol in the medication cart. The resident has not had any tramadol for a while and he/she did not know why it was not reordered. The MAR showed the last tramadol given was May 24, 2022. Resident complained of pain at 6:15 A.M., and was given Tylenol. The CMT L would expect the medications to be reordered and available for the resident. CMT L would expect the nurse to be informed of the need to reorder any medications or issues with getting any medications. Per the MAR, the resident was getting oxycodone and then tramadol until May 24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/22/22 at 12:30 P.M., Licensed Practical Nurse (LPN) A said he/she was just informed the tramadol was not in the medication cart. The last tramadol was given on May 24, 2022. There was an active order for this medication. He/she called the pharmacy and they said there was no issues with the medication and it will be sent stat (immediately). LPN A would expect the medication to be ordered from the pharmacy and available for the resident. LPN A would expect the CMTs to notify the nurse of unavailable medications or the delivery of medications. During an interview on 6/22/22 at approximately 1:00 P.M., the ADON said she would expect staff to administer pain medication if requested by the resident and as ordered. If a medication was not available, she would expect staff to call the pharmacy for a refill, stat. If staff are unable to obtain the medication, she would expect staff to inform the physician and ask for alternative in the meantime. If the resident has Tylenol or other over the counter medications (OTC), they would be offered. During an interview on 6/22/22 at approximately 1:30 P.M., the administrator said he would expect residents to receive pain medication as ordered. If unavailable, he would expect nursing to order the medication from pharmacy. If unavailable to obtain, physician should be aware of the issue. Also, he would expect the nurse/CMT to the let the DON and/or administrator know of any issue. Staff should offer other medications until the requested medication was available. He was unaware of this issue related to the resident's tramadol. MO00200737

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	06/22/2022

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40290 Based on observation, interview and record review, the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The census was 119. Review of the facility's Facility Assessment Tool, updated 6/17/22, showed: -Average daily census: approximately 120; -Facility resources needed to provide competent support and care for our resident population every day and during emergencies: -Staff type, included: Administration, nursing services (e.g., Director of Nursing (DON), RN, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), certified nurse aides (CNAs) or nursing assistant-registered (NARs), medication aide or technician, Minimum Data Set (MDS) nurse); -Staffing plan: The facility employs clinical and nonclinical staff to care for residents, and seeks to staff at the following ratios: -Licensed nurses: RN, LPN, LVN providing direct care. DON: 1 DON RN. LPN: 1 per 40 residents or less during shifts 1 and 2; 1 per 60 residents or less during shift 3; -Direct care staff: A combination of LPNs, CMTs, and CNAs to achieve a per patient day (PPD) of 2.3 or more. Review of the staffing sheets and time punches for RN H, (the only RN which was from agency) from 6/1/22 through 6/21/22, showed: -On 6/1/22 through 6/9/22, no other RN worked any shift; -On 6/11/22 through 6/14/22, no other RN worked any shift; -On 6/14/22, no other RN worked any shift; -On 6/17/22 through 6/21/22, no other RN worked any shift. During an interview on 6/21/22 at 2:50 P.M. with the administrator and Regional Nurse Consultant (RNC) D, the administrator said he began working in his position at the facility in the middle of May 2022. The administrator and RNC D said they were not sure what the facility's RN coverage should be. The administrator said the DON and staffing coordinator quit over the weekend. The facility does not have an RN on staff. Agency staff, particularly as RN H, is utilized to fill in for RN coverage. There are two RNCs who work with the facility on an ongoing basis and both are RNs, but neither are on the schedule for RN coverage. The facility has job postings for an RN position on the facility's website and a hiring website. (continued on next page)

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	06/22/2022

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/22/22 at 12:21 P.M., the assistant Director of Nurses (ADON) said the facility should have an RN scheduled to work eight hours a day, seven days a week. MO00202759