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	12/24/2019

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 35394 Based on observation, interview and record review, the facility failed to assess a resident's ability to safely self-administer their own medications for one resident when staff left medications at the bedside (Resident #43). The sample was 29. The census was 146. Review of the facility's Self-Administration policy, dated 3/1/02, showed: -Residents who express no desire to participate will have all medication administration functions handled by the facility; -If the resident desires to participate, the facility's Interdisciplinary Team (IDT) will evaluate the resident's cognitive, physical, and visual ability to self-medicate using the self-medication evaluation tool; -All self-medication assessments will be kept in the clinical record under assessments tab; -The program will be included in the resident's care plan; -Monthly documentation of the resident's response to this program will be completed by a licensed nursing personnel in conjunction with monthly summaries or separately as assigned. Review of Resident #43's medical record, showed the following: -A quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/18/19, showed diagnoses of anemia, high blood pressure, dementia, seizure, and kidney disease; -No order to self-administer medications; -No assessment for the ability to self-administer medications. Review of the resident's care plan, in use at the time of the survey, showed no documentation for the ability to self-administer medication. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/20/19 at 8:50 A.M., showed the resident lay in bed with his/her arms over his/her face. A medication cup was located on the bedside table with approximately seven pills inside. The resident was asked if he/she just received his/her medication. He/she removed his/her arms from over his/her face, looked at the medication cup and said, I guess so and placed his/her arms over his/her face. Licensed Practical Nurse (LPN) E stood at the medication cart on the hall. LPN E confirmed that he/she administered the medications and the resident said he/she would take them. LPN E did not see the resident take his/her medications. LPN E said the resident was assessed to show that he/she could safely take medications without staff present. During an interview on 12/20/19 at 4:41 P.M., the Director of Nursing (DON) said the resident was not able to self-administer his/her medications. In order for a resident to self- administer, they would have to show a desire and staff would complete an assessment. She would expect the nurse to stay in the room with the resident to ensure all medications were taken.

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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** 32847 35394 36151 Based on observation, interview and record review, the facility failed to provide a clean, comfortable and homelike environment in common areas, on the 100 hall, 3 South, 2 Main and 3 Main. In addition, the facility failed to provide a clean, comfortable and homelike environment for one resident with bubbled and peeled paint above his/her bed (Resident #142), one resident with a brown substance on the floor (Resident #60) and nine resident rooms with a variety of environmental concerns (rooms 126, 132, 330, 332, 333, 334, 335, 336 and 338). The census was 146. 1. Observations of the 100 Hall on 12/17/19 at 9:00 A.M., during the environmental tour, showed the following: -The water fountain, between the nurse's station and the sunroom, inoperable; -The shower room, across from the South nurse's station, on the left side of the hall: -A broken shower chair, the seat of the chair lay on the floor. On the chair, a note which read not working properly'; -The kick plate on the back of the shower room entrance/door, covered with black streaks, the perimeter of the doorway, covered with build-up and dirt; -The shower room, across from the South nurse's station, on the right side of the hall: -The kick plate on the back of the shower room entrance/door, covered with black streaks, the perimeter of the doorway, covered with build-up and dirt; -Inside the shower, along the left side, a darkened area extended upward, approximately 12 inches from the base of the shower. The area on the left bottom side of the shower, covered with a blackened area, approximately 3 inches tall by 24 inches wide; -The plumbing, extending upward from the rear of the toilet, approximately 2 feet, covered in a blueish/green residue. 2. Observation on 12/17/19 at 9:12 A.M., during the environmental tour of 3 South, showed: -In the hall outside of the elevator near room [ROOM NUMBER]: One area of missing and chipped floor tiles approximately 3 inches by 3 inches. A second area approximately 8 inches by 1 inch with missing and chipped floor tiles; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the 3 south dining room, the ceiling in the right far corner with an area that measured approximately 4 feet by 4 feet of missing tiles. The ceiling in the area with the missing tiles with a black discoloration. 3. Observation on 12/18/19 at 6:31 A.M., on 2 Main, showed a dried, red substance on the door handle of the shower room. The substance measured approximately 2 inches long. Certified Nurse Aide (CNA) R entered the shower room. He/she used the door handle to open the door. CNA R exited the shower room with a paper towel to dry his/her hands. CNA R did not clean the dried, red substance off the door handle. At 6:46 A.M., housekeeping staff entered the 2 main unit. He/she saw the dried, red substance on the door handle and put gloves on his/her hand. He/she wiped the door handle before entering the shower room. 4. Observations on 3 Main, on 12/17/19 at 2:30 P.M., 12/19/19 at 5:15 P.M., and 12/20/19 at 8:00 A.M., showed the following: -Shower room with a crack in the cove base in the shower area; -The dining room with two ceiling tiles that had a brownish discoloration on them. 5. Review of Resident #142's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/26/19, showed: -Cognitively intact; -Diagnoses included anxiety disorder and depression. During an interview on 12/17/19 at 9:20 A.M., the resident said this place is falling apart, staff do not make repairs when things break. Observation of the resident's room at this time, showed an area approximately 3 feet by 2 feet on the ceiling above the resident's bed, with paint bubbled, peeled and chipped. During an interview on 12/20/19 at 3:11 P.M., the Maintenance Director said he was not aware of the area above the resident's bed. The bubbling paint is probably from moisture. There had been a water leak in the next room over that had been repaired. It is possible the leak also affected the resident's room. He would expect staff to report the issue. 6. Observation of Resident #60's room on 12/17/19 at 4:44 P.M., 12/18/19 at 6:23 A.M., 12/19/19 at 6:31 A. M., and 12/20/19 at 9:20 A.M., showed several areas of a dried, brown substance on the bathroom floor. During an interview on 12/20/19 at 3:28 P.M., the Housekeeping Supervisor said the resident bathrooms are cleaned daily. Resident #60 eats brownies all the time, but the housekeeper is expected to clean daily. 7. Observations of the 100 Hall on 12/17/19 at 9:00 A.M., during the environmental tour, showed the following: -In room [ROOM NUMBER]: Caulk missing around the sink basin; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In room [ROOM NUMBER]: Caulk missing around the sink basin. 8. Observation of the environment during the initial tour of the facility, on 12/17/19 at 2:30 P.M., 12/19/19 at 5:15 P.M., and 12/20/19 at 8:00 A.M., showed the following: -Rooms 330, 332, 333, 334, 335, 336 and 338: The metal appliance behind the toilet with a greenish discoloration; -room [ROOM NUMBER]: The caulk around the toilet cracked; -room [ROOM NUMBER]: Tiles missing from the bathroom wall, near the floor; -room [ROOM NUMBER]: Broken titles on the bathroom wall, near the floor. 9. During an interview on 12/20/19 at 3:11 P.M., the Maintenance Director said any staff person can report an environmental concern to maintenance. Maintenance staff complete room audit check sheets periodically. The sheets were part of the Quality Assurance and Performance Improvement (QAPI) plan. The maintenance director said he tours the facility and makes room audits every month, looking for issues that need to be corrected. There had been a leak in the dining room on 3 south and he was aware of the issue. The leak was fixed and the area just needs new ceiling tiles. The greenish discoloration noted in the bathroom on the metal appliance is probably from condensation and caused by lime build-up. The brownish discoloration on the third floor main ceiling tiles is probably caused by steam from the steam tables. 10. During an interview on 12/20/19 at 3:28 P.M., the Housekeeping Supervisor said housekeeping staff complete a check of the walls two times per week. They complete rounds of the building weekly, every Monday and Friday to look for any issues with housekeeping. If housekeeping notices a problem that needs to be repaired, housekeeping will notify maintenance. Housekeeping cleans the resident bathrooms daily. 42247

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 32847 Based on interview and record review, the facility failed to issue written transfer notices to residents and/or their representative upon transfer to a hospital when their return to the facility was expected, for seven of eight residents investigated for discharge notices. The sample was 29. The census was 146. Review of the facility's General Administrative/Discharges and Transfers policy, dated 10/1/19, showed: -It is the policy of the facility to ensure residents are treated equally regarding transfer, discharges and the provision of services, regardless of their payment source in accordance with state and federal regulations; -The policy failed to direct staff to provide the resident with a transfer notice upon transfer to a hospital. 1. Review of Resident #40's medical record, showed: -On 9/18/19, admitted to the facility; -On 10/9/19, discharge return anticipated; -On 10/10/19, reentry to the facility; -On 12/12/19, discharge return anticipated; -On 12/16/19, reentry to the facility; -No documentation of transfer notices. 2. Review of Resident #124's medical record, showed: -On 4/17/09, admitted to the facility; -On 10/21/19, discharge return anticipated; -On 11/4/19, reentry to the facility; -No documentation of a transfer notice. 3. Review of Resident #72's medical record, showed: -On 3/27/17, admitted to the facility; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/16/19, discharge return anticipated; -On 10/25/19, reentry to the facility; -No documentation of a transfer notice. 4. Review of Resident #74's medical record, showed: -On 1/29/08, admitted to the facility; -On 11/19/19, discharge return anticipated; -On 11/27/19, reentry to the facility; -No documentation of a transfer notice. 5. Review of Resident #118's medical record, showed: -On 6/2/16, admitted to the facility; -On 11/25/19, discharge return anticipated; -On 11/30/19, reentry to the facility; -No documentation of a transfer notice. 6. Review of Resident #68's medical record, showed: -On 4/30/19, admitted to the facility; -On 8/16/19, discharge return anticipated; -On 8/20/19, reentry to the facility; -No documentation of a transfer notice. 7. Review of Resident #120's medical record, showed: -On 1/30/18, admitted to the facility; -On 11/25/19, discharge return anticipated; -On 12/3/19, reentry to the facility; -No documentation of a transfer notice. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an interview on 12/23/19 at 12:14 P.M., the Director of Nursing said the nurse who transfers the resident to the hospital is responsible to provide the resident or representative with the transfer notice. 35394 36151 42247

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 32847 Based on interview and record review, the facility failed to inform the resident, family and/or legal representative of their bed hold policy at the time of transfer to the hospital when their return to the facility was expected, for seven of eight residents investigated for bed hold notices. The sample was 29. The census was 146. Review of the facility's Bed Hold policy, dated 12/18/18, showed: -It is the policy of this facility to inform and notify a resident and/or their legal representative of their rights and obligations pertaining to the facility's bed hold policies at the time of admission and upon a temporary leave of absence; -A temporary leave of absence is a situation in which a resident is discharged from the facility as a result of a hospitalization or therapeutic home stay. 1. Review of Resident #40's medical record, showed: -On 9/18/19, admitted to the facility; -On 10/9/19, discharge return anticipated; -On 10/10/19, reentry to the facility; -On 12/12/19, discharge return anticipated; -On 12/16/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfers. 2. Review of Resident #124's medical record, showed: -On 4/17/09, admitted to the facility; -On 10/21/19, discharge return anticipated; -On 11/4/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfer. 3. Review of Resident #72's medical record, showed: -On 3/27/17, admitted to the facility; -On 10/16/19, discharge return anticipated; (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 10/25/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfer. 4. Review of Resident #74's medical record, showed: -On 1/29/08, admitted to the facility; -On 11/19/19, discharge return anticipated; -On 11/27/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfer. 5. Review of Resident #118's medical record, showed: -On 6/2/16, admitted to the facility; -On 11/25/19, discharge return anticipated; -On 11/30/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfer. 6. Review of Resident #68's medical record, showed: -On 4/30/19, admitted to the facility; -On 8/16/19, discharge return anticipated; -On 8/20/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfer. 7. Review of Resident #120's medical record, showed: -On 1/30/18, admitted to the facility; -On 11/25/19, discharge return anticipated; -On 12/3/19, reentry to the facility; -No documentation the resident or representative was issued a bed hold policy upon transfer. 8. During an interview on 12/23/19 at 12:14 P.M., the Director of Nursing said the nurse who transfers the resident to the hospital is responsible to provide the resident or representative with the bed hold notice. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	35394 36151 42247

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 37672 Based on observation, interview and record review, the facility failed to ensure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment for two of 29 sampled residents (Residents #60 and #43). The census was 146. 1. Review of Resident #60's medical record, showed an active order dated 4/26/19, for intermittent straight catheterization (temporary insertion of a urinary catheter into the bladder to drain urine) three times a day. Resident may straight catheterize self. Review of the resident's quarterly Minimum Data Sets (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/1/19 and 10/1/19, showed intermittent catheterization not indicated. 2. Review of Resident #43's medical record, showed an active order dated 6/4/19, to check and record vitals before and after dialysis (the process of filtering toxins from the blood in individuals with kidney failure) two times a day every Tuesday, Thursday and Saturday. Review of the resident's quarterly MDS, dated [DATE], showed dialysis not indicated. 3. During an interview on 12/20/19 at 3:36 P.M., MDS coordinator JJ said the MDS should be accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36151 Based on interview and record review, the facility failed to ensure residents with a mental disorder and individuals with intellectual disability as determined by the DA-124c level I screen (used to evaluate for the presence of psychiatric conditions), indicating the required preadmission screening/resident review (PASARR, level II screen), had one completed for one of 29 sampled residents (Resident #8). The census was 146. Review of Resident #8's face sheet, showed: -admitted to the facility on [DATE]; -Diagnoses included schizoaffective disorder (a psychiatric disorder in which either a major depressive or a manic episode develops concurrently, displaying the symptoms of schizophrenia), psychotic disorder (delusions, hallucinations, talking incoherently, and agitation) and anxiety disorder. Review of the resident's medical record, showed: -DA-124c level I screen, dated 3/16/16, indicated a PASARR level II was required; -No PASARR level II screen found. During an interview on 12/20/19 at 5:19 P.M., the Director of Nursing said she was unable to locate the resident's PASARR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific care needs of the residents, for 10 out of 29 sampled residents (Residents #71, #2, #393, #114, #106, #93, #40, #60, #21 and #118). The census was 146. 1. Review of Resident #71's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/8/19, showed: -Cognitively intact; -Has the resident wandered: Behavior not exhibited; -No behaviors; -Limited assistance required to transfer; -Limited assistance for locomotion off the unit; -Diagnoses included anxiety disorder, depression and psychotic disorder; -No falls. Review of the facility's resident roster, showed the resident resided on the locked unit. Review of the facility's policy and procedure for the Secure Horizon Program, provided as the requirements for residents to be placed on the locked units, revised 8/31/12, showed: -The facility will implement psychiatric rehabilitation services called the Secure Horizon Program which has the primary purpose of providing therapeutic interventions to individuals diagnosed with a serious mental illness; -Program Goals: To improve or maintain the resident's level of functioning and independence; encourage the engagement of each resident in his/her recovery and rehabilitation; increase acquisition, performance and retention of skills to enhance independence and when possible promote community integration; support the progressive assumption of as much personal responsibility, self-management, and self-determination as each resident can manage; broaden the use of living, coping, and occupational skills to new environments with an ultimate goal of discharge to more independent arrangements as appropriate; decrease psychotic, self-injurious, antisocial and aggressive behaviors; decrease impact of cognitive deficits and impediment to learning new skills; and foster the human dignity, persons worth and quality of life of each resident; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Program overview: The facility may utilize any combination of therapeutic modalities designed to address the individual's needs of residents with a serious mental illness. This may include assignment to a secure unit, a level system: and skills training group; -The policy did not identify the requirements for placement on the locked unit or how the facility will assess a resident's appropriateness to be placed on the unit. Review of the resident's care plan, in use at the time of the survey, showed: -The resident has a history of aggressive behaviors related to anger, attention seeking behaviors and gets upset. States staff ignores him/her. Diagnoses of anxiety, history of physical aggression. Laughs and cries inappropriately. Unable to say what makes him/her sad. Childlike affect, gets upset and states no one wants to be his/her friend. History of biting his/her wrist, stating he/she is afraid to be here; -The care plan failed to identify the need to be placed on a locked unit, goals to be achieved with placement on the locked unit, identify goals for less restrictive placement and interventions to meet goals related to placement on the locked unit. During an interview on 12/17/19 at 11:40 A.M., the resident cried and said he/she wanted to go back to the 1st floor. He/she hates it up here and he/she felt he/she was being punished. During an interview on 12/19/19 at 8:57 A.M., the Social Service Director (SSD) said, regarding the different floors, on the resident's floor there are less privileges. It is less restrictive and residents gain more privileges when they move down off the locked unit. Sometimes residents are moved to the unit because they do not get along with their roommates. During an interview on 12/20/19 at 5:27 P.M., the Director of Nursing (DON) said residents are assessed to determine if they are appropriate for the locked unit mainly using their diagnoses and behavior. The resident was placed on the locked unit because he/she lashed out and staff felt the floor was more appropriate. The resident likes the attention he/she gets on the locked unit. The resident's care plan should address the reason for being placed on the unit, goals to be achieved and goal to return to the 1st floor. 2. Review of Resident #2's annual MDS, dated [DATE], showed: -Cognitively intact; -How important is it to have books, newspapers and magazines to read: Somewhat important; -How important is it to listen to music you like: Very important; -How important is it to keep up with the news: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Somewhat important; (continued on next page)

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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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-How important is it to participate in religious services or practices: Very important; -Diagnoses included depression. Review of the resident's activities participation documentation, showed: -An activity participation note, dated 8/27/19, the resident comes to very few activities. He/she sends a list for staff to go shopping for him/her. He/she has been encouraged to come to activities. He/she enjoys reading and watching his/her television programs. Review of the resident's care plan, in use at the time of the survey, showed activity preferences not addressed. Goals and interventions to increase activity participation not addressed. During an interview on 12/17/19 at 8:00 A.M., the resident said he/she wished he/she had some books to read. During an interview on 12/20/19 at 3:45 P.M., the Activity Director said he/she wished he/she knew the resident wanted books, because the library visited earlier in the day and he/she could have gotten a book for him/her. 3. Review of Resident #393's admission MDS, dated [DATE], showed: -Cognitively intact; -How important is it to listen to music you like: Very important; -How important is it to be around animals such as pets: Very important; -How important is it to keep up with the news: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Very important; -How important is it to participate in religious services or practices: Very important; -Diagnoses included anxiety and depression. Review of the resident's Activity Participation Notes, showed: -On 10/6/19, the resident is new to the facility. He/she is a nonsmoker who enjoys music and television. He/she is Catholic and wants to come to services on Monday mornings. He/she enjoys bingo and Italian food; -On 12/20/19, the resident establishes his/her own agenda. He/she stays to him/herself and refuses to do any activities on or off the unit. He/she will socialize with staff in short sentences when asked a question. He/she has come to the beauty shop to get a haircut a couple of times since his/her admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 10/10/19, showed activity preferences not care planned. Goals and interventions to increase activity participation not addressed. Observation of the resident on 12/17/19, showed the resident walked the halls. He/she said he/she has been at the facility about 2-6 weeks. 4. Review of Resident #114's annual MDS, dated [DATE], showed: -Cognitively intact; -How important is it to have books, newspapers and magazines to read: Very important; -How important is it to listen to music you like: Very important; -How important is it to keep up with the news: Very important; -How important is it to do things with groups of people: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Very important; -How important is it to participate in religious services or practices: very important; -Diagnoses included schizophrenia. Review of the resident's care plan, in use at the time of the survey, showed activity preferences not care planned. Review of the resident's Activity Participation Notes, showed: -On 8/8/19, spoke to the resident about his/her likes in activities. He/she continues to like money games and anything dealing with food. He/she also enjoys music and movies. The resident will go on trips when he/she has money to shop and enjoys food outings. He/she comes to exercise bingo; -On 11/14/19, the resident establishes his/her own agenda. He/she enjoys movies and popcorn and happy hours. The resident usually takes out all of his/her spending money very early and spends it, preventing him/her from going on shopping trips. He/she also enjoys ice cream socials and birthday parties. During an interview on 12/17/19 at 3:38 P.M., the resident said he/she wants more activities on the floor, not just the ground level. Observation of the resident's room showed no activity calendar available. The resident said he/she does not know where it went. 5. During an interview on 12/20/19 at 3:45 P.M., the Activity Director said the facility currently has four activity staff. He/she just got the position of activity director as the position was vacant. Activity preferences are assessed by staff talking to the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 12/23/19 at 12:14 P.M., the DON said for residents that do not routinely attend activities, they would benefit from routine one on one visits. If a resident's comprehensive MDS indicated an activity as important, she would expect the areas marked be provided to the resident and included in the resident's plan of care. 7. Review of Resident # 106's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Signs and symptoms of possible swallowing disorders: None; -Weight loss of five percent or more in the last month or 10% or more in the last six months: No or unknown; -Nutritional approach: None; -Dental section: Blank; -Eating with set up and supervision only; -Diagnoses included: high blood pressure, ulcerative colitis (chronic, inflammatory bowel disease), high cholesterol, dementia, Parkinson's disease (a disorder of the brain that leads to tremors, difficulty with walking, movement and coordination), manic depression (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), psychotic disorder (disorder characterized by a disconnection from reality) and schizophrenia (long-term mental disorder, involving a breakdown in the relation between thought, emotion and behavior). Review of the resident's current electronic physician order sheet (ePOS), showed: -Ensure Liquid (nutritional supplements), give 240 milliliters (mL) by mouth after meals for weight loss; -An order dated 11/18/19, for weekly weights, weight every Monday related to mild protein-calorie malnutrition; -Ready Care 2.0 three times a day related to mild protein-calorie malnutrition; -Scopolamine base patch (used to treat nausea) 72 Hour 1.5 milligram (mg), apply 1 patch transdermal (on the skin) every 3 days for nausea and vomiting/excessive secretions; -Diet: regular texture, regular consistency. Review of the resident's comprehensive care plan, in use at the time of survey showed: -Problem: The resident consumes a mechanical soft diet; -Goal: The resident will not have signs and symptoms of aspiration. Weight to remain stable thru next review; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Diet as ordered, dietician to evaluate as needed, monitor weight monthly and as needed, inform the medical doctor of significant weight changes. During an interview on 12/20/19 at 4:30 P.M., MDS coordinator HH said both the care plan and the ePOS should match. The MDS coordinator is responsible to be ensure the care plan is accurate and reflects diet orders accurately. 8. Review of Resident #93's quarterly MDS, dated [DATE], showed: -Extensive assistance with two person physical assistance with bed mobility; -Diagnoses of insomnia. Review of the resident's ePOS, showed: -An order dated 3/7/17, for melatonin (natural sleep aide) 5 mg, give one by mouth at bedtime for insomnia; -An order dated 8/19/18, may have bed rails; -An order dated 12/6/19, for Trazodone HCl (sedative and antidepressant) 50 mg, give one tablet by mouth at bedtime for insomnia. Review of the resident's side rail assessment, dated 7/20/18, showed side rails indicated to assist with positioning/support. Review of the resident's care plan, dated 10/24/19, showed: -No documentation of side rails, interventions, or diagnosis to support the use of side rails; -No documentation of the use of insomnia medication, interventions, or goals. Observation on 12/18/19 at 6:18 A.M., 12/19/19 at 6:37 A.M. and 8:46 A.M. and 12/20/19 at 7:42 A.M., showed the resident in bed with both quarter side rails raised on the bed. 9. Review of Resident #40's ePOS, showed: -An order dated 9/26/19, to cleanse suprapubic catheter (urinary catheter inserted through the abdominal wall to drain urine) site daily with normal saline or wound cleanser. Place drain sponge around area and secure daily; -An order dated 10/10/19, to flush suprapubic catheter daily with sterile water, 30 milliliter (ml) every day shift for irrigation; -An order dated 10/17/19, to change suprapubic catheter every three weeks; -An order dated 12/7/19, for Duoderm (protective dressing). Apply to coccyx (tail bone area) topically one time a day every three days; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order dated 12/18/19, for Venelex Ointment ([NAME]-[NAME] Oil). Apply to sacrum (buttocks/tailbone area) topically every day shift, every two days for pressure ulcer (injury to the skin and/or underlying tissue, as a result of pressure or friction). Clean with normal saline or wound cleaner, skin prep (protective barrier wipe) to periwound (intact skin surrounding a wound), apply Venelex ointment to wound bed, cover with foam dressing and apply to sacrum topically as needed for pressure ulcer; -An order dated 12/18/19, for foam Dressing Bordered Pad (wound dressings). Apply to sacrum topically every day shift, every two days for pressure ulcer after skin prep and Venelex, apply to sacrum topically as needed for pressure ulcer. Review of the resident's care plan, dated 10/10/19, showed: -No documentation of the resident's catheter, interventions, goals, and diagnosis to support the use of the catheter; -No documentation of the resident's pressure ulcer, interventions, goals, and stage of the pressure ulcer. Observation on 12/18/19 at 6:45 A.M. and 11:36 A.M., 12/19/19 at 6:45 A.M. and 2:34 P.M., and 12/20/19 at 7:30 A.M. and 11:49 A.M., showed the resident in his/her bed. The catheter tubing and drainage bag on the left side of the bed. 10. Review of #60's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Rejects care one to three days; -Diagnoses of benign prostatic hyperplasia (BPH, urinary tract blocked by large prostate) and diabetes; -Frequently incontinent of bowel and bladder. Review of the resident's ePOS, showed an order dated 4/26/19, for intermittent straight catheterization (temporary insertion of a urinary catheter to drain urine) three times a day for BPH. The resident may straight catheterize self per physician. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: The resident experienced bladder incontinence related to a neurogenic bladder (difficulty with emptying the bladder due to neurological conditions); -Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date; -Interventions: Staff to check the resident at least every two hours and as needed for incontinence. Provide incontinent care. Staff may catheterize as needed; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan did not address the resident ability to self-catheterize, education required or supplies needed for the resident. 11. Review of Resident 21's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Assistance of one staff person for bed mobility and dressing; -Assistance of two staff person for transfers and toileting; -Upper/lower extremity impairment on one side; -Wheelchair for mobility; -Diagnoses included stroke, seizure disorder, high blood pressure, diabetes and anemia. Review of the resident's nurse's note, dated 11/17/19 at 10:30 P.M., showed: -Nurse assistant putting resident to bed at 9:00 P.M. He/she slid from the end of the bed, nurse assistant held resident as he/she slid down with him/her to keep him/her from hurting him/herself. Resident stated he/she was not hurt, just slid to the floor. Resident was uninjured during this time. Resident alert and orientated; -Further review of the progress note, showed staff failed to follow the resident's care plan during the transfer, resulting in a fall. Review of the resident's care plan, in use during the survey, showed: -Problem: At risk for falls due to seizure, spastic movements, non-ambulatory, and decreased cognitive skills. History of left sided weakness. Fall on 9/13/19, noted on floor in shower room, attempted to transfer self from toilet. On 9/29/19, fell during transfer of one staff no injuries; -Approaches: The resident will not sustain serious injury through the review date. The resident will be free of injury due to falls. Continue to educate/re-educate staff on proper transfers of two person assist. Continuous staff education on safe transfers. Educate on importance of waiting for assistance with transfers. Educate staff to use 2 persons to transfer resident. Educate staff to lock wheelchair prior to transfer. Educate staff on transfer with gait belt and resident requires two person transfer; -The care plan was not updated with current fall, 11/17/19. During an interview on 12/19/19 at 10:08 A.M., the DON said she would expect new employees to ask and/or reference the resident's care card if not familiar with the resident's transfer status. 12. Review of Resident 118's quarterly MDS, dated [DATE], showed: -Cognitively intact; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Two staff person assist for activities of daily living; -Upper/lower extremity impairment of both sides; -Wheelchair for mobility; -One Stage III pressure ulcer (full thickness tissue loss injury to the skin as a result of pressure or friction, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed); -One unstageable pressure ulcer (depth of the wound is unable to be determined); -Diagnoses included quadriplegia (paralysis of all four limbs), multiple sclerosis, (MS, disease in which the immune system eats away at the protective covering of nerves), heart failure, high blood pressure, kidney failure and diabetes. Further review of the resident's MDS records, showed: -discharge date of [DATE]; -Entry date of 11/30/19. Review of the resident's wound assessment, dated 12/18/19, showed: -Wound #1, Right ischial (area of the skin where the leg connects to the buttocks) is an acute Stage III pressure injury ulcer, measuring 0.8 centimeter (cm) length by 1 cm width by 0.5 cm depth, with an area of 0. 8 square cm and a volume of 0.4 cubic cm. Undermining (wound open underneath the border of the wound) has been noted at 9 o'clock (visual location based on the face of a clock) and ends at 3 o'clock with a maximum distance of 1.6 cm. There is a moderate amount of serosanguineous (clear, blood tinged) drainage noted with no odor. The patient reports a wound pain of level 0 out of 10; -Wound #2, Left Ischial is an acute Stage III pressure injury, measuring 3.5 cm length by 2.7 cm width by 0.8 cm depth, with an area of 9.45 square cm and a volume of 7.56 cubic cm. No drainage noted. Patient reports a pain level of 0 out of 10. During an interview on 12/18/19 at 11:45 A.M., Nurse Practitioner W said the resident was hospitalized on [DATE] and returned with a worsened wound from the hospital. He/she went from a stage II (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough, may also present as an intact or open/ruptured blister) to a stage III. The area on his/her left side had worsened. Review of the resident's care plan, in use during the survey, showed: Problem: Resident has a history of having a healed unstageable pressure ulcer to the right ischium. He/she is at risk for developing other pressure related areas due to refusing to offload the area, incontinent of bowel and requiring assistance with turning and repositioning while in bed. He/she refuses to return to bed once he/she gets up into the motorized wheelchair and stays up for prolonged period of times. On 10/15/19, stage II ulcers to right ischium; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Approach: Skin will remain intact through review date. Inform resident/family/caregivers and physician of any new area of skin breakdown. Instruct/assist him/her with shifting his/her weight in wheelchair on a frequent basis. Needs monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Monitor/document/report as needed any changes in skin status. Treatment to right ischium as ordered, inform physician if treatment plan is unsuccessful; -Further review of the care plan, showed the care plan not updated with a pressure area to left ischium. During an interview on 12/20/19 at 5:38 P.M., the DON said the resident's care plan should have been updated and the pressure area to the left ischium noted on the care plan. 13. During an interview on 12/20/19 at 3:36 P.M., MDS Coordinator JJ said the care plans should be correct and accurate and represent the resident's medical status and needs. The MDS Coordinators and the unit managers will update the care plans when the resident experienced a change. The care plan drives the care of the resident and staff are trained to use the care plan as a reference for care and needs. 35394 36151 42247

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 32847 Based on interview and record review, the facility failed to ensure a resident discharged to the community had a recapitulation of stay, final summary of status, reconciliation of all pre-discharge and post-discharge medications and post-discharge plan of care completed for one of two residents investigated for discharge to the community (Resident #83). The census was 146. Review of Resident #83's medical record, showed: -On 12/9/19 at 12:33 P.M., the social worker spoke with a friend to inquire about placement for the resident. The friend stated he/she made plans to pick the resident up today (12/9/19). Social worker will continue to assist the resident with discharge plans; -On 12/9/19 at 4:27 P.M., discharged home with medications and narcotics. Ambulatory to car with friend; -No documentation of a recapitulation of stay, final summary of the resident's status, reconciliation of all pre-discharge and post-discharge medications and post-discharge plan of care. During an interview on 12/20/19 at 4:25 P.M., the Director of Nursing said the Social Service Director has a note dated 12/9/19 where she talked with the resident about discharge. They have no further information and no documentation of a discharge summary.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on observation, interview and record review, the facility failed to ensure staff were able to provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care in accordance with physician's orders and the resident's advance directives by failing to have a system in place to ensure resident's code status was documented and that staff were able to quickly identify a resident's code status when needed. The facility failed to obtain an ordered code status for 13 residents (Residents #13, #77, #103, #67, #75, #26, #54, #104, #126, #87, #88, #97 and #32), failed to ensure residents'/resident representatives wishes for code status matched the physician ordered code status for two residents (Residents #107 and #114), failed to ensure one resident's code status was ordered timely after admission (Resident #40) and failed to ensure a process for staff to know a resident's code status in the event of electrical or electronic medical record outage. This had the potential to affect all residents who resided in the facility. The sample was 29. The census was 146. The administrator was notified on [DATE] at 1:43 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility's untitled policy, dated [DATE], provided as the facility's policy and procedure for resident code status and advanced directives, showed: -While awaiting a physician's order to withhold cardiopulmonary resuscitation (CPR, the manual application of chest compressions and ventilations to patients in cardiac arrest), facility staff should immediately document discussions with the resident or resident representative, including, as appropriate, a resident's wishes to refuse CPR (DNR, do not resuscitate). At minimum, a verbal declination of CPR by a resident, or if applicable a resident's representative, should be witnessed by two staff members. While the physician's order is pending, staff should honor the documented verbal wishes of the resident or the resident's representative, regarding CPR; -Advance directives: The right to formulate an advance directive applies to each and every resident and facilities must inform residents of their option to formulate advance directives. If a resident has a valid advance directive, the facility's care must reflect the resident's wishes as expressed in their directive; -Facility Policies: Facility policies should address the provision of basic life support and CPR, including: -Directing staff to initiate CPR when cardiac or respiratory arrest occurs for residents who do not show obvious clinical signs of irreversible death and who have requested CPR in their advanced directives or who have not formulated an advanced directive or who do not have a valid DNR order; -The policy failed to identify the process to document code status and to assure the code status is congruent and available during electronic medical record down time. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Review of Resident #13's electronic physician order sheet (ePOS), reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. Review of the social service signed code status binder, located in the social service office, showed no signed code status. During an interview on [DATE] at 7:41 P.M., the Social Service Director (SSD) said he/she obtained verbal wishes for a full code on [DATE]. 2. Review of Resident #77's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. Review of the social service signed code status binder, located in the social service office, showed full code, signed [DATE]. During an interview on [DATE] at 7:41 P.M., the SSD confirmed the resident's code status form was signed on [DATE] as a full code. There was no order for the full code in the ePOS. 3. Review of Resident #103's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 4. Review of Resident #67's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 5. Review of Resident #75's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. Review of the social service signed code status binder, located in the social service office, showed no signed code status. 6. Review of Resident #26's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 7. Review of Resident #54's ePOS, reviewed on [DATE], showed no ordered code status. (continued on next page)

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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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 8. Review of Resident #104's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 9. Review of Resident #126's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 10. Review of Resident #87's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. Review of the social service signed code status binder, located in the social service office, showed no signed code status. 11. Review of Resident #88's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 12. Review of Resident #97's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 13. Review of Resident #32's ePOS, reviewed on [DATE], showed no ordered code status. Review of the resident's electronic medical record, showed the resident admitted to the facility on [DATE]. 14. During an interview on [DATE] at 8:56 A.M., the SSD said she is responsible to obtain a resident's code status wishes upon admission. If she is off work, the charge nurse is responsible. 15. During an interview on [DATE] at 10:07 A.M., the Director of Nursing (DON) said resident code statuses are reviewed during the quarterly care plan meetings. A resident without a code status should have been identified as not having a code status at the quarterly meeting. 16. Review of Resident #107's ePOS, showed an order dated [DATE], for full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on [DATE] at approximately 9:15 A.M., showed Licensed Practical Nurse (LPN) I passed medications to residents on the hall. A staff person came out of the resident's room and asked LPN I to call Assistant Director of Nursing (ADON) A. ADON A came to the floor, then two staff members came out of the resident's room and told LPN I the resident expired and time of death was 9:21 A.M. No CPR was performed. LPN I continued to pass medications to residents on the hall. During an interview on [DATE] at 10:08 A.M., LPN I said he/she needed to look in the computer to know the resident's code status. LPN I looked in the computer and said he/she was having trouble finding the code status, but I know the resident is a DNR, otherwise staff would have done CPR. At 10:15 A.M., LPN I said Nurse Practitioner (NP) W was the person who came to him/her to call ADON A. The resident was on hospice and was a DNR. The ePOS said full code, but the resident is on hospice. During an interview with ADON A at this time, he/she said he/she was called to the floor. NP W was in to see the resident and he/she did not hear heart or lung sounds. He/she also checked and did not hear anything. The resident was a DNR and the death was expected. During an interview on [DATE] at 10:20 A.M., the administrator said she would check into the resident's code status. She was pretty sure the code status was changed in the hospital to a DNR. Code status should be updated and accurate. The nurse who admitted the resident should make sure the code status is updated. The administrator went to the second floor and talked with staff about the resident's code status. ADON A got the hospice binder out of the office and said the resident came back from the hospital as a full code. NP W talked with the guardian and the code status was changed to DNR. The administrator said she would expect the code status on the form and the electronic chart to match. It would be the nurse who admits a resident who is responsible to enter the code status into the electronic medical record. If a residents code status is changed after a resident is admitted , it would be the nurse who was on duty at the time the code status was changed to enter the information into the computer. Review of the signed code status form, located inside the hospice binder, showed a DNR form signed [DATE] by the guardian. During an interview on [DATE] at approximately 12:00 P.M., Hospice Case Manager S said the resident went on hospice on [DATE] and he/she believed the resident was already a DNR. If hospice obtained the DNR order, they would take the order to the hospice medical director and have the order signed. Hospice would set up a binder and the information would be in the binder at the facility. If they believed the facility already had the resident as a DNR, they would not do this. If the resident was already a DNR at the facility, the facility would be responsible to maintain the order for DNR. During an interview on [DATE] at 1:32 P.M., NP W, the NP for the Medical Director, said the resident was a DNR. When the resident admitted last week, he/she saw him/her the day after. He/she discussed hospice with Guardian Y. Guardian Y then changed the resident to a DNR. Usually he/she would give a verbal order or he/she will put the order for the DNR into the system. Then staff send the code status sheet to the Medical Director for signature. He/she was not sure if that was done for the resident. He/she gave the verbal order for the DNR. Once the order was given, the order should be entered into the computer and faxed over to the Medical Director's office. He/she talked with ADON A, LPN N and Staff X last week about the DNR order. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 2:27 P.M., Guardian Y said he/she prepares the DNR form and the form is based on a questionnaire he/she receives from the physician. He/she has a signed questionnaire for the resident signed by the physician from the hospital. Review of the signed questionnaire, faxed on [DATE] at 2:38 P.M., showed it contained questions about the resident's condition and no order for code status. 17. Review of Resident #114's medical record, showed an order dated [DATE], for full code. Review of the social service signed code status binder, located in the social service office, showed a signed code status sheet dated [DATE], for DNR. During an interview on [DATE] at 11:31 A.M., LPN H said he/she is the nurse for the resident. Everything is in the computer. Staff know a code status by looking in the computer. 18. Review of Resident #40's ePOS, showed an order dated [DATE], for DNR. Review of the social service signed code status binder, located in the social service office, showed a signed code status sheet dated [DATE], for full code. Further review of the social service signed code status binder, showed a signed code status for a DNR not obtained until [DATE]. 19. During an interview on [DATE] at 8:56 A.M., the SSD said she is responsible to obtain the signed code status sheets. After it is signed, she used to make a copy and place it in the paper chart, but the facility no longer has paper charts. She now keeps them in a binder in her office. Some care coordinators will ask for a copy of them as well. If a copy is not given to the care coordinator, then the copy in her office is the only copy. When she is not at work, her office is locked. If staff needed to access the code status binder when she is not at the facility, the maintenance staff and administrator have a key to the office and would have to come down and unlock it. She is just now learning how to scan the signed code status sheets into the electronic medical record. She would expect the physician order match the signed code status sheet. 20. During an interview on [DATE] at 10:07 A.M., the DON said resident code statuses are reviewed during the quarterly care plan meetings. A resident with an incongruent code status should have had this identified during the quarterly care plan meeting. 21. During an interview on [DATE] at 10:34 A.M., LPN E said the facility has no paper charts. When asked where advanced directives were located, he/she said good question, he/she would have to get back to the surveyor on that. During an interview on [DATE] at 11:31 A.M., LPN H said everything is in the computer. Staff know a resident's code status by looking in the computer. During an interview on [DATE] at 11:36 A.M., LPN Q said the residents' code status is in the electronic medical record. That is the only place it is located, since the facility went electronic. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 3:17 P.M., Care Coordinator B and LPN C said if a resident ceased to have signs of life, they would check them to verify no vital signs. They then come to the electronic medical chart to see if the resident was a full code. If they were a full code, they would start CPR. If the computers were down, they were not sure where they would look. If a resident is a new admission, upon admission the step of obtaining a code status order is part of the admission process. If a code status changes, staff document in progress notes, but they have to contact social services. Staff need to have the conversation with the resident or representative witnessed. Social services usually changes the documentation of code status. During an interview on [DATE] at 3:18 P.M., LPN J said if a resident ceased to have signs of life, he/she would call a code over the intercom and at the same time have someone check the resident's code status. Code status is checked in the computer. During an interview on [DATE] at 3:19 P.M., Certified Nursing Assistant (CNA) D said if a resident were to cease having signs of life, he/she would get the nurse. He/she is new and is not sure how to know a resident's code status. During an interview on [DATE] at 3:26 P.M., CNA BB said if he/she found a resident unresponsive or expired, he/she would check to see if they had a pulse, then run and tell the charge nurse. During an interview on [DATE] at 3:28 P.M., CNA CC said if he/she found a resident unresponsive or maybe expired, he/she would run out and check the code status in the electronic chart. If the resident was a full code, he/she would page overhead and run back to start CPR. If the resident was a DNR, he/she would just tell the charge nurse the resident expired. During an interview on [DATE] at 3:28 P.M., LPN E said if he/she found a resident with no signs of life, he/she would try some lifesaving measures initially and yell code. If it is found the resident was a DNR on the computer, he/she would stop life saving measures. He/she has been at the facility for 4 years. If the computers go down, he/she would not be able to check the code status. The computers have gone down in the past on several occasions. They are down for an hour or so at a time. If he/she does not know the code status, he/she is doing CPR. 22. During an interview on [DATE] at 4:20 P.M., with the administrator and DON, the DON said upon admission, if a resident did not come with an order for a code status, staff ask the physician for one. The physician usually talks to the family and gives staff an order. When asked who was responsible for making sure a resident has a code status, the DON said she was not sure she knew how to answer that. She knew the SSD plays a role in it. Code status is on the electronic physician order sheet and on the care card at the nurse's station. Each nurse's station has a binder with a care card for each resident and that is where code status is documented. They heard some staff did not know where to find the code status, so the care coordinators are in-servicing staff right now. If the computers go down, staff are to refer to the care card. She would expect the advanced directives policy be followed. If the policy requires two witnesses to a DNR request from the resident or family, this would be documented in the nurse's notes. She would expect the facility policy to address how code status will be documented. Staff should be aware of the care cards. Observation and interview on 1 south and 1 Main on [DATE] at 4:46 P.M., showed a CNA binder at the nurses stations. LPN J said the CNA care card binders have been at the nurse's station, he/she would have never thought to look there for a resident's code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation and interview on 2 south on [DATE] at 4:35 P.M., showed Care Coordinator B walked down the hall with a binder in his/her hand and said it was the CNA care card binder that will be kept in the cabinet on 2 south. The care coordinators are in-servicing staff now on the location of the CNA care card binders. He/she will also be doing an audit. Observation and interview on 2 Main on [DATE] at 4:35 P.M., showed the care card binder at the nurses station. LPN E said he/she did not know how often the CNA care card binders are updated and he/she had never looked in the binder. Review of the binder at this time, showed 13 residents documented in the binder without a code status identified. Observation and interview on 3 south on [DATE] at 4:30 P.M., showed LPN F pulled up a resident's care card in the computer and said there is no care card on paper. During observation and interview on 3 main on [DATE] at 4:35 P.M., LPN G said he/she knew there was a book on the left side of the wall, in the cubby, but he/she was unsure which book was the CNA care card book. LPN G asked another staff member to get the book down for him/her because he/she could not reach the book. Staff got the book down and it was not the CNA care card binder. The staff person got down a second book and it was the CNA care card binder. The book showed some of the residents who resided on the floor missing from the book, Residents #95, #70, #5, #393 and #50. 23. During an interview on [DATE] at 5:41 P.M., the administrator said the Quality Assurance and Performance Improvement team had not identified code status as an issue. The facility switched over from paper charting to the electronic records and they had not identified the location of resident code statuses as an issue. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level L. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the F level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). 42247

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on observation, interview and record review, the facility failed to provide, based on the comprehensive assessment, care plan and preferences of each resident, an ongoing program to support residents in their choice of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, for eight of nine residents identified by the facility as residing on a locked floor, not attending routine activities and not provided one on one activities (Residents #2, #22, #393, #48, #113, #139, #78 and #81). One resident identified a desire to have more activities take place on the locked floors (Resident #114). In addition, residents who resided on 2 Main and requires staff with a key card to enter and exit the floor, did not have activities provided to them on the floor. The sample was 29. The census was 146. 1. Review of Resident #2's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/17/19, showed: -Cognitively intact; -How important is it to have books, newspapers and magazines to read: Somewhat important; -How important is it to listen to music you like: Very important; -How important is it to keep up with the news: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Somewhat important; -How important is it to participate in religious services or practices: Very important; -Diagnoses included depression. Review of the resident's activities participation documentation, showed: -A quarterly/annual participation review, dated 2/28/18; -No further quarterly/annual participation review assessments; -An activity participation note, dated 11/10/17, the resident establishes his/her own agenda. He/she enjoys snack related activities, church, parties, and shopping. The resident likes to go on shopping trips or he/she sends a list for the staff to pick up items. He/she enjoys watching television shows in his/her room and in the dining room; -An activity participation note, dated 8/27/19, the resident comes to very few activities. He/she sends a list for staff to go shopping for him/her. He/she has been encouraged to come to activities. He/she enjoys reading and watching his/her television programs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, in use at the time of the survey, showed activity preferences not addressed. During an interview on 12/17/19 at 8:00 A.M., the resident said he/she wished he/she had some books to read. During an interview on 12/20/19 at 3:45 P.M., the Activity Director said he/she wished he/she knew the resident wanted books, because the library visited earlier in the day and he/she could have gotten a book for him/her. They come once a month. On 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 2. Review of Resident #22's annual MDS, dated [DATE], showed: -Cognitively intact; -Clear speech, distinct intelligible words; -Makes self understood; -Understands, clear comprehension; -Hearing: Adequate, no difficulties; -Should interview for daily and activity preferences be conducted: No, resident is rarely/never understood; -Diagnoses included depression. Review of the resident's activities documentation, showed: -An admission activities initial review, dated 12/5/17; -No quarterly/annual participation review assessments; -An activity note dated 12/20/19 at 5:06 P.M., resident establishes his/her own agenda. He/she gets money whenever he/she has funds available to purchase snacks out of the machine. He/she is on a locked unit and when asked to come to activities for an event, he/she always refuses. The resident is always quiet, but will speak if addressed; -No further activity assessments or participation documented. Review of the resident's care plan, dated 12/9/18, showed: -The resident's preferred activities are staying in his/her room by him/herself; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Explain to the resident the importance of social interaction, leisure activity time. Encourage his/her participation; -Offer road trips on days he/she is not scheduled to go to treatments, which occurs every other Wednesday. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 3. Review of Resident #393's admission MDS, dated [DATE], showed: -Cognitively intact; -How important is it to listen to music you like: Very important; -How important is it to be around animals such as pets: Very important; -How important is it to keep up with the news: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Very important; -How important is it to participate in religious services or practices: Very important; -Diagnoses included anxiety and depression. Review of the resident's Activity Participation Notes, showed: -On 10/6/19, the resident is new to the facility. He/she is a nonsmoker who enjoys music and television. He/she is Catholic and wants to come to services on Monday mornings. He/she enjoys bingo and Italian food; -On 12/20/19, the resident establishes his/her own agenda. He/she stays to him/herself and refuses to do any activities, on or off the unit. He/she will socialize with staff in short sentences, when asked a question. He/she has come to the beauty shop to get a haircut a couple of times since his/her admission. Review of the resident's activities initial review, dated 12/11/19, showed the resident enjoys staying in his/her room. He/she looks at his/her roommate's television in his/her room. The resident will sometimes come out of his/her room on the unit for church in the unit. He/she refuses to attend any activities in or outside the facility. He/she says he/she is a loner. He/she is in a locked unit and requires supervision from staff to leave unit. Review of the resident's care plan, dated 10/10/19, showed activity preferences not care planned. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the resident on 12/17/19, showed the resident walked the halls. He/she said he/she has been at the facility about 2-6 weeks. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 4. Review of Resident #48's annual MDS, dated [DATE], showed: -Cognitively intact; -How important is it to have books, newspapers and magazines to read: Very important; -How important is it to listen to music you like: Somewhat important; -How important is it to keep up with the news: Somewhat important; -How important is it to do your favorite activities: Somewhat important; -Diagnoses included psychotic disorder. Review of the resident's care plan, dated 10/3/17, showed: -Updated 7/3/19, the resident has little or no activity involvement related to disinterest and wishes not to participate. He/she is an introvert and is content with his/her level of activity participation; -The resident will express contentment with his/her level of activity participation; -Allow to watch TV in the common room when prefers; -Invite/encourage family members to attend activities with resident in order to support participation; -Modify daily schedule, treatment plan as needed to accommodate activity participation as requested by the resident; -Monitor/document for impact of medical problems on activity level. Review of the residents Participation Review assessments, showed: -On 9/15/17, Activities Initial Review completed; -On 9/21/18, Activities Quarterly Participation Review completed; -No further annual or quarterly activity reviews documented. Review of the resident's Activity Participation Notes, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/9/19, the resident establishes his/her own agenda. He/she likes to read and meditate. At times he/she will go watch television in the back television room. He/she was offered to move off of the floor, but declined; -On 10/20/19, the resident continues to establish his/her own agenda. He/she does not like to come off of the unit. He/she likes to read and will sometimes sit in the back room and watch television; -No further activity participation documented. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 5. Review of Resident #113's annual MDS, dated [DATE], showed: -Moderately impaired cognition; -Adequate hearing; -Clear speech, distinct intelligible words; -Makes self understood; -Understands, clear comprehension; -Should interview for daily and activity preferences be conducted: No, resident is rarely/never understood; -Diagnoses included Alzheimer's disease. Review of the resident's Activities Quarterly/Annual Participation Review assessment, showed completed 7/25/17. No further quarterly or annual activity participation review assessments completed. Review of the resident's Activity Participation Notes, showed: -On 8/9/18, the resident establishes his/her own agenda. He/she likes to watch television in his/her room. He/she will come get coffee and snacks from activities on occasion. He/she also likes to get vending machine money each day; -On 11/14/19, the resident establishes his/her own agenda. He/she enjoys watching television in his/her room. He/she enjoys sweet treats and gets out daily money to go to the snack machine. Staff has invited him/her several times off the unit, but he/she refuses; -No further activity participation documented. Review of the resident's care plan, dated 11/12/19, showed: (continued on next page)

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	265585	A. Building B. Wing	12/24/2019

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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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/15/19 update: The resident prefers to spend most of his/her time in his/her room. He/she is at risk for social isolation; -The resident will have adequate stimulation. Staff will continue to encourage out of/off unit activities; -Encourage the resident to attend psychological group meetings; -Invite and encourage the resident to attend scheduled activities; -Provide a calendar in the resident's room with upcoming events. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 6. Review of Resident #139's annual MDS, dated [DATE], showed: -Rarely/never understood; -How important is it to have books, newspapers and magazines to read: Somewhat important; -How important is it to listen to music you like: Very important; -How important is it to do things with groups of people: Somewhat important; -How important is it to do your favorite activities: Very important; -How important is it to participate in religious services or practices: Somewhat important; -Diagnoses included Alzheimer's disease and dementia. Review of the resident's Activities Quarterly/Annual Participation Review assessment, showed completed 8/30/17. No further quarterly or annual activity participation review assessments completed. Review of the resident's Activity Participation Notes, showed: -On 8/20/18, the resident enjoys listening to music on a daily basis. He/she enjoys ice cream and talking about his/her younger days in Mississippi. He/she enjoys watching some movies at times and getting snacks; -No further activity participation notes documented. Review of the resident's care plan, dated 12/10/19, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident has participated in the activities that he/she enjoys such as listening to old time blues and he/she prefers to sit in the doorway and monitor his/her room. He/she talks and interacts with others as they walk down the hallway. He/she communicates with staff and other residents in the activities area during movie and music time; -The resident will participate in activities of choice two times per week; -The resident prefers watching and talking to staff/other residents while she is sitting outside of her bedroom door; -Remind him/her that he/she may leave activities at any time, and is not required to stay for entire activity. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 7. Review of Resident #78's annual MDS, dated [DATE], showed: -Moderately impaired cognition; -How important is it to have books, newspapers and magazines to read: Somewhat important; -How important is it to listen to music you like: Somewhat important; -How important is it to keep up with the news: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Somewhat important; -How important is it to participate in religious services or practices: Somewhat important; -Diagnoses included schizophrenia. Review of the resident's Activities Initial Review assessment, showed: -Completed on 11/2/16 and 10/17/17; -No further activities annual or quarterly assessments documented. Review of the resident's Activity Participation Notes, showed: -On 7/18/17, the resident participates in snack related activities and goes on outings. He/she remains a supervised smoker on the locked unit; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/15/19, staff spoke with the resident about his/her likes and dislikes in activities. The resident likes to play bingo at times. He/she still enjoys snack related activities. He/she remains a supervised smoker on the locked unit. The resident prefers to stay on the unit most days, because he/she doesn't like to walk far; -On 10/20/19, the resident likes to establish his/her own agenda. He/she likes music and bingo sometimes. He/she remains a supervised smoker on the locked unit. Review of the resident's care plan, dated 10/15/19, showed activity preferences not care planned. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 8. Review of Resident #81's annual MDS, dated [DATE], showed: -Cognitively intact; -How important is it to have books, newspapers and magazines to read: Very important; -How important is it to keep up with the news: Very important; -How important is it to do things with groups of people: Somewhat important; -How important is it to do your favorite activities: Somewhat important; -How important is it to go outside to get fresh air when the weather is good: Very important; -How important is it to participate in religious services or practices: Very important; -Diagnoses included depression and anxiety. Review of the resident's Activity Participation Notes, showed: -On 7/18/17, the resident remains a supervised smoker on the locked unit. He/she enjoys bingo and snack related activities. He/she also has family that visits and brings him/her food and candy; -On 7/15/19, the resident spoke to staff about his/her likes and dislikes. He/she enjoys sweet snacks and coffee and news in the morning. He/she likes to play bingo sometimes, but prefers to stay on the unit. He/she has family that come see him/her and brings him/her cigarettes each month. He/she is a supervised smoker on the locked unit; -On 10/20/19, the resident continues to be a supervised smoker on the locked unit. He/she enjoys playing bingo if it is done on the locked unit. He/she has family that he/she calls and that comes to visit with him/her. Review of the resident's Activities Quarterly/Annual Participation Review assessment, showed completed 4/12/18. No further quarterly and annual participation review assessments completed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 10/22/19, showed: -The resident has little or no activity involvement related to depression. The resident goes to activities, but does not participate, enjoys sitting at nurse's station waiting to smoke. Also likes to sit in his/her doorway and observe passer-byers; -The resident will be content with his/her level of participation in activities as evidenced by few emotional outbursts thru next review period; -Allow the resident to sit in doorway during waking hours; -The resident's preferred activities are bingo and smoking cigarettes; -Staff will encourage participation in activities and socialization. During an interview on 12/23/19 at 9:29 A.M., the Activity Director identified the resident as a resident who resides on a locked unit and does not routinely attend activities off of the floor. The resident receives friendly visits, but does not receive one on one activities. 9. Review of Resident #114's annual MDS, dated [DATE], showed: -Cognitively intact; -How important is it to have books, newspapers and magazines to read: Very important; -How important is it to listen to music you like: Very important; -How important is it to keep up with the news: Very important; -How important is it to do things with groups of people: Very important; -How important is it to do your favorite activities: Very important; -How important is it to go outside to get fresh air when the weather is good: Very important; -How important is it to you to participate in religious services or practices: Very important; -Diagnoses included schizophrenia. Review of the resident's care plan, in use at the time of the survey, showed activity preferences not care planned. Review of the resident's Activities Initial Review assessment, showed completed on 10/26/17. No further annual or quarterly Activity Participation Review assessments documented. Review of the resident's Activity Participation Notes, showed: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/9/18, the resident participates in activities daily. He/she likes to play exercise bingo and regular bingo. The resident also likes to go on the shopping outings when he/she can; -On 8/8/19, spoke to the resident about his/her likes in activities. He/she continues to like money games and anything dealing with food. He/she also enjoys music and movies. The resident will go on trips when he/she has money to shop and enjoys food outings. He/she comes to exercise bingo; -On 11/14/19, the resident establishes his/her own agenda. He/she enjoys movies and popcorn and happy hours. The resident usually takes out all of his/her spending money very early and spends it, preventing him/her from going on shopping trips. He/she also enjoys ice cream socials and birthday parties. During an interview on 12/17/19 at 3:38 P.M., the resident said he/she wants more activities on the floor, not just the ground level. Observation of the resident's room, showed no activity calendar available. The resident said he/she does not know where it went. 10. During an interview on 12/20/19 at 3:45 P.M., the Activity Director said the facility currently has four activity staff. He/she just got the position of activity director, as the position was vacant. Activity preferences are assessed by staff talking to the residents. The activity department provides activities on the locked units two times a week. Which locked unit the activity is provided on, varies. When activities are provided on a locked unit, residents from the other locked units are invited. Sometimes these activities include staff bringing popcorn and movies upstairs. Activity staff visit the floor every day to bring the residents coffee. Activity wise, if a resident doesn't come down off the units, activity staff will sometimes do friendly visits. These are not documented. Residents who receive one on one activities have documentation to show the one on one activities took place. He/she is not aware of any resident who voiced they want more activities on the units. There is no way to know, based on the activity calendar, where the scheduled activity is going to occur. 11. Observation of the 2 Main hall, showed a key card required to enter the floor. Residents unable to enter or leave the floor without assistance of a staff person with a key card. During an interview on 12/23/19 at 9:29 A.M., the Activity Director said activities are provided on the main floor activity room and on the third floor locked units two times a week. Review of 2 Main's activity calendar, located in the dining room, dated 12/17/19, showed: -At 8:30 A.M., coffee and news; -At 10:15 A.M., exercise and bingo; -At 2:15 P.M., popcorn mania. Observation of the residents on 2 Main on 12/17/19 at 8:30 A.M., 10:15 A.M., and 2:15 P.M., showed: -At 8:30 A.M., residents seated in the dining room eating a meal. No observation of the coffee and news activity provided by staff; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:30 A.M., no observations of exercise bingo or other activities; -At 2:15 P.M., no observations of residents consuming popcorn or involved in other activities. Review of 2 Main's activity calendar, located in the dining room, dated 12/18/19, showed: -At 8:30 A.M., coffee and news; -At 10:15 A.M., crafts; -At 2:15 P.M., staff game of choice; Observation of the resident's on 2 Main on 12/18/19 at 8:30 A.M. and 2:15 P.M., showed: -At 8:30 A.M., residents seated in the dining room eating a meal. No observation of the coffee and news activity provided by staff; -At 2:15 P.M., no observations of residents playing a game or other activities with staff. Review of 2 Main's activity calendar, located in the dining room, dated 12/19/19, showed: -At 8:30 A.M., coffee and news; -At 10:15 A.M., activity meeting; -At 2:00 P.M., cake walk. Observation of the resident's on 2 Main on 12/19/19 at 8:30 A.M. and 2:00 P.M., showed: -At 8:30 A.M., residents seated in the dining room eating a meal. No observation of the coffee and news activity provided by staff; -At 2:00 P.M., no observations of activity staff on the unit serving cake to the residents. Review of 2 Main's activity calendar, located in the dining room, dated 12/20/19, showed: -At 8:30 A.M., coffee and news; -At 10:15 A.M., exercise fun; -At 2:30 P.M., ice cream social. Observation of the resident's on 2 Main on 12/20/19 at 8:30 A.M., showed: -At 8:30 A.M., residents seated in the dining room eating a meal. No observation of the coffee and news activity provided by staff. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/19 at 6:52 A.M., Licensed Practical Nurse (LPN) RR said regarding activities provided to the residents on 2 Main, activity staff come up to the unit. He/she did not know how often the residents received activities. During an interview on 12/20/19 at 3:54 P.M., the Director of Activities said he/she was not sure if there was a calendar posted on 2 Main; however, it is on the television. The activities are the same week by week, but it depends on what the residents like. Every morning they receive coffee and at 9:00 A.M., they are served snacks and cocoa. On Tuesdays after lunch, they are served popcorn and on Wednesdays they are served a snack. After lunch, staff would talk to them and watch TV in the big room. The residents like to look at the cars drive by. The residents enjoy ball toss, ice cream social, pet therapy, and bingo. The Director of Activities confirmed the same calendar located on 2 Main was the same calendar throughout the facility. 12. During an interview on 12/23/19 at 12:14 P.M., the Director of Nursing said for residents on the locked floors that do not routinely attend activities, they would benefit from routine one on one visits. She would expect activity staff to document quarterly on residents. If a resident's comprehensive MDS indicated an activity as important, she would expect the areas marked be provided to the resident. One on one visits should be documented.

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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 - Minimal harm or potential for 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** 35394 Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for one resident who had a diagnostic procedure canceled due to the resident not having a next of kin who was able to be contacted. The facility failed to take steps to assist the resident to find an individual to make medical decisions for the resident. This resulted in the resident having a delay in the diagnosing of symptoms. The resident had a change of condition, went to the hospital and was diagnosed with intussusception (condition in which one segment of intestine telescopes inside of another, causing an intestinal obstruction), requiring surgery (Resident #124). One resident had a change in condition documented and no further documented assessments for approximately 12 hours, when the resident expired (Resident #144). In addition, staff failed to communicate blood sugar levels that were out of range to the physician for one resident (Resident #68). The sample was 29. The census was 146. Review of the facility's Change in Condition policy, dated ,d+[DATE], showed: -It is the responsibility of licensed staff to contact the physician and the resident's responsible party whenever there is a change in the resident's physical, mental or psychosocial status; -Acute change in condition is sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional status that, without intervention, may result in complications or death; -Non-urgent change in condition is a deviation from a patient's baseline in physical, cognitive, behavioral or functional status that is not reasonably expected to result in complications or death or may be a persistent or intermittent result of the patient's diagnosed disease state; -Upon identification of any change in condition, licensed nursing personnel will contact the resident's attending physician/on-call physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition while non-urgent changes should occur no later than 72 hours from the noted change; -All notifications should be preceded by an appropriate physical, mental or psychosocial assessment to enable the physician to make adequate and appropriate treatment and/or transfer decision; -Following notification of the physician, licensed nursing personnel will contact the resident's responsible party to inform him/her of the change. For acute changes in condition, this should occur immediately when practicable and after addressing the resident's immediate needs and for non-urgent changes in condition, the notification should occur within 72 hours of the noted change; -All notification should be documented to include: Date and time, name of the individual contacted, specific reasons for the notification, any specific responses that were given by the person contacted; -The policy did not address documentation and follow up of the resident's condition after the initial identification. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #124's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated [DATE], showed: -Rarely understood; -Diagnoses included anemia (low red blood cell count), high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), colitis (inflammation of the colon), diabetes, non-Alzheimer's dementia, schizophrenia (severe mental disorder that affects thinking), restlessness and agitation; -Signs and symptoms of delirium present; -Wandering exhibited in the last ,d+[DATE] days; -Independent with bed mobility and transfers; -Supervision with dressing, eating, and hygiene. Review of the resident's care plan, updated [DATE] and in use during the survey, showed: -Focus: Resident has impaired cognition function related to dementia: -Goal: Resident will maintain current level of cognitive function through the review date. Resident will be able to communicate basic needs on a daily basis through the review date; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; -Focus: Resident has communication problem: -Goal: Resident will be able to make basic needs known; -Interventions: Encourage him/her to continue stating thoughts even if he/she is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling he/she is trying to express. Review of the resident's labs, showed: -On [DATE], a hemoglobin (red blood cell count) result of 7.8; -Hemoglobin reference range, ,d+[DATE]. Review of the resident's electronic physician orders sheet (ePOS), showed: -An order dated [DATE], for STAT (immediately) stool guaiac (lab test used to determine if there is blood in the stool), diagnosis of anemia; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order dated [DATE], for clear liquids, no food the entire day, for pre-procedure order for colonoscopy (diagnostic procedure used to diagnose conditions of the intestines) scheduled [DATE], related to anemia; -An order dated [DATE], for nothing by mouth (NPO) after midnight for procedure; -An order dated [DATE], for gastrointestinal appointment for colonoscopy related to anemia; -An order dated [DATE], for pre-procedure orders for colonoscopy [DATE]. On [DATE] start low fiber diet. On [DATE], hold iron complex. On [DATE], hold blood thinner (Plavix). On [DATE], start clear liquid diet. Give Golytely (liquid medication used to evacuate the colon and intestine of all stool) 1 liter (L) at 5:00 P.M., 8 ounces (oz) every 15 minutes. On [DATE] nothing by mouth (NPO) except: give another liter of Golytely at 4:00 A.M., 8 oz every 15 minutes. May take medications with sips of water; -An order dated [DATE], for Golytely solution reconstituted 236 gram (gm). Give 1 L by mouth one time only related to anemia for three days. Give 8 oz every 15 min minutes until first liter is completed. Give another liter the following at morning at 4:00 A.M.; -An order dated [DATE], to discharge to hospital for evaluation and treatment. Review of the resident's progress notes, showed: -No documentation staff attempted to contact the next of kin to inform of the change in condition or needed STAT laboratory test. No documentation staff notified social services if contact could not be made; -On [DATE] at 3:02 P.M., resident up and about on unit. Assisted with activities of daily living (ADLs). Respiration even and non-labored. Lung sounds clear. Abdomen soft and round with active bowel sounds times four quadrants. Resident informed that a stool collection is needed today. Specimen placed inside of toilet to obtain stool sample; -On [DATE] at 8:56 A.M., (23 days after the order to obtain the stool sample, ordered on [DATE] STAT) call placed to lab pending guaiac stool. He/she did not see specimen results, but will contact supervisor to see where is specimen is waiting; -On [DATE] at 2:43 P.M., called placed to hospital regarding instructions to prep related to colonoscopy scheduled for [DATE]. No answer received at this time. Left message. Will await call. No documentation staff attempted to contact the next of kin for consent of the diagnostic procedure or notified social services if contact could not be made; -On [DATE] at 8:55 A.M., resident is up and about on unit. Remains NPO related to colonoscopy scheduled today at 11:00 A.M. Completed Golytely as ordered. Tolerated well. Remains alert and oriented times two. Respirations even and non-labored. Lung sounds clear times two. Abdomen soft and round with active bowel sounds times four quadrants. Gait and balance steady; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE] at 10:56 A.M., spoke to hospital staff. He/she informed writer that the resident's colonoscopy scheduled for [DATE] was not performed due to his/her cognitive deficits. He/she was unable to tell them if he/she had drank the prep prior to coming for the procedure, he/she could not verbalize understanding of the procedure or why it needed to be performed. He/she stated the resident was alert and oriented to person only. He/she also stated that he/she attempted to reach his/her emergency contacts and no one answered either number. Staff informed them that they would make Nurse Practitioner W aware of the conversation; -On [DATE] at 11:09 A.M., notified Nurse Practitioner W of the conversation from hospital staff. He/she stated that he/she was aware and has been unsuccessful in locating a family member to give consent for the procedure. No documentation staff notified social services that contact with the next of kin for consent could not be made; -On [DATE] at 6:59 P.M., resident holding on to railing walking down the hall, holding onto railing to assist with balance, at times was given a wheelchair to use and after sitting in the wheelchair for short periods of time, would get up to continue to walk; -On [DATE] at 11:14 P.M., resident holding on to railing walking down the hall, gait extremely unsteady and requires more assistance than usual. Nurse Practitioner W notified about change in condition. No documentation staff attempted to contact the next of kin regarding the change in condition or notified social services if contact could not be made; -On [DATE] at 11:31 P.M., resident was noted lowering him/herself to the floor in the hallway during dinner. Resident has required frequent help transferring with unsteady gait. No injury noted at this time. Nurse Practitioner W contacted with no new orders; -On [DATE] at 3:17 P.M., resident was observed sitting down on the floor x 2 today. Resident assisted off of the floor onto a wheelchair as his/her gait is unsteady and bilateral lower extremities weakness noted as his/her legs buckled under him/her when staff assisted him/her off of the floor. Resident encouraged to use the wheelchair to propel him/herself so he/she does not fall. Resident re-directed back to his/her wheelchair a couple of times as he/she was observed getting out of the wheelchair trying to walk. Resident sits back in the wheelchair when re-directed; -On [DATE] at 9:33 P.M., resident is noted in bed watching TV. He/she is able to make needs known and required frequent help with transfer and ambulation this shift. Resident does not pick feet up off the ground at times. He/she is sliding feet and shuffling feet quite often. No complaints of pain voiced at this time; -On [DATE] at 10:59 P.M., while walking down the hall, resident holds furniture and the railings. Wheelchair offered to resident, however he/she does not sit in the chair; -On [DATE] at 2:58 P.M., resident is alert/responsive to person, up ambulating slowly on the unit. Resident encouraged to sit down on the hallway bench from time to time and he/she has been compliant with that request. Resident's gait is slow, unsteady; -On [DATE] at 2:27 P.M., resident continues to sit on the floor throughout shift which is care planned for resident. Resident also continues to hold on to railing walking down the hallway and does not walk upright; (continued on next page)

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	265585	A. Building B. Wing	12/24/2019

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE] at 10:59 P.M., resident was noted with large bowel sitting at anal opening while lying on his/her side during Certified Nurse Aide (CNA) round. The bowel was the size of a baseball. No distress was noted from resident. No signs/symptoms of pain nor discomfort noted. Resident did refuse CNA assistance. This writer showered resident, provided fresh linen and encouraged fluids since bowel was noted hard and formed. Vital signs are within normal limits for this resident at this time; -On [DATE] at 11:00 A.M., resident received orders from Nurse Practitioner W to be discharged to the hospital for evaluation and treatment. Follow up with Hepatitis C management and overall decline. No documentation staff attempted to contact the next of kin regarding the resident being sent to the hospital or notified social services if contact could not be made; -On [DATE] at 2:22 P.M., received call from nurse at hospital; the resident is being admitted to the hospital with a diagnosis of intussusception (obstruction) of the intestines. Review of the resident's medical record, showed no social services notes regarding an attempt to locate next of kin or someone with decision making capabilities for the resident. Further review of the resident's labs, showed: -On [DATE], hemoglobin 7.9; -On [DATE], hemoglobin 8.3; -On [DATE], hemoglobin 7.4; -On [DATE], hemoglobin 7.9; -On [DATE], hemoglobin 8.0; -Reference range of ,d+[DATE]. Review of the resident's fecal occult blood immunochemical (a test that detects hidden blood in the stool and screens for colon cancer) lab result, showed: -Collection date of [DATE] (20 days after the STAT order was obtained); -Reported date of [DATE]; -Result: negative. Review of the resident's physician's progress notes, showed: -On [DATE]: History of Present Illness: Resident with continued weight loss and poor appetite. Often refusing to eat meals even when he/she is brought to the dining room. He/she recently went for a colonoscopy, but was unable to get consent for procedure, family was unable to be contacted, so they sent him/her back to the facility. He/she denies any pain at this time; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On [DATE]: History of Present Illness: Resident with continued weight loss over the last few months. His/her appetite has been poor and he/she often refuses to go to meals. He/she is noted to have some weight loss of ten pounds over the last month; -On [DATE]: History of Present Illness: Per nursing discussion: vital signs, weight loss has been at a steady decline, no hospitalization s in the last month. Decline cognitive and physical status. Resident is noted to still not be eating regularly. He/she also has been noted to be laying on the floor, which has been a regular behavior for him/her lately; -On [DATE]: History of Present Illness: Resident had some weight loss with generalized allover decline over the last few months. His/her dementia has been worsening and he/she has been experiencing failure to thrive. Lately he/she has not been able to get up. He/she has been noted to lay on the couch and urinate on him/herself. He/she has increased incontinence of fecal and urine. His/her Hepatitis C markers have come back elevated; -Plan: Sent to hospital for evaluation due to weight loss and generalized decline; -On [DATE]: History of Present Illness: Resident recently readmitted to the facility following hospitalization for fecal mass, intussusception of the intestine and severe malnutrition. He/she was sent out due to further decline with mobility and mentation, for cancer work-up. Computed tomography (CT, scan makes use of computer-processed combinations of many X-ray measurements taken from different angles). He/she received laparoscopic right colectomy (a surgical procedure to remove all or part of your colon). Since he/she has been back at the facility, he/she has been improving as far as his/her mentation and eating habits. Review of the resident's hospital records, dated [DATE] through [DATE], showed: -admitted on [DATE]; -Primary discharge diagnosis: Intussusception; -Secondary discharge diagnosis: Cecum mass (a lump of volume of tissue in the beginning of the large intestine), intussusception intestine, and severe malnutrition; -History of present illness: Resident with untreated hepatitis C, dementia, schizoaffective disorder, and high blood pressure, who lives in a nursing home and had weight loss and worsening mental status. Nursing home sent him/her to hospital for possible cancer work up. His/her liver enzymes were normal. Vital signs are within normal range. Urinalysis (test to detect urinary tract infections) was negative. CCT scan showed long segment intussusception extending from the distal ileum (the end of the small intestine before it transitions into the large intestine) to the ileocecal valve (sphincter muscle valve that separates the small intestine from the large intestine). He/she was admitted for evaluation and possible surgical treatment. Patient was admitted with intussusception and he/she underwent Golytely prep with multiple enemas in preparation for colonoscopy prior to surgical intervention; -By [DATE], patient had not been adequately prepped despite persistent bowel prep/enemas, so the decision was made to precede with operating room for laparoscopic right colectomy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:53 P.M., Licensed Practical Nurse (LPN) N said the resident did not receive a colonoscopy, because the resident was not able to give consent for the procedure. He/she was his/her own responsible party. He/she had a family member, but they could not be reached. His/her information was also sent to the hospital and they were unsuccessful in getting information. The resident had a steady decline before [DATE] and it was hard to get to the bottom of what was going on, because he/she did not have anyone to sign for him/her. It was hard to send him/her to the hospital. He/she is a poor historian and does not have anyone to talk for him/her. Obtaining a public administrator was not that simple; however, LPN N did not know how that worked. LPN N remembered Nurse Practitioner W asked someone at the hospital regarding how they could obtain consent for the resident. During an interview on [DATE] at 4:00 P.M., the Director of Social Services said she might have heard about the resident in need of someone to consent for him/her. She was not aware that due to the resident not having anyone to consent for him/her, he/she was not able to proceed with the colonoscopy appointment. If a resident was able to make decisions at the time of admission and later declined and they could no longer make medical decisions, they would call the next of kin. The Director of Social Services was not aware of what the next step would be if there was a resident without a next of kin. She did not know if there was a facility policy that addressed guardianship. She had never contacted a public administrator at any point since she had been employed with the facility, nor assisted anyone with guardianship at any point in her career as a social worker, and did not know the process. During an interview on [DATE] at 9:18 A.M., Nurse Practitioner W confirmed that the resident needed the colonoscopy; however, he/she could not consent. He/she needed an acute reason to go to the hospital. The hospital was not going to keep him/her at first. He/she had a cousin that was listed, but there was no answer. That also happened at the doctor's office and at the hospital. He/she could not consent. During an interview on [DATE] at 5:26 P.M., the Director of Nursing (DON) said if the physician said to reach out to the family and get a guardian, or get the social worker and the Ombudsman involved to see what the options were, the facility would have done that. There was no sense of urgency, but there was a conversation about the issue. The nurse practitioner attended the clinical meetings and spoke with the physician about the resident. The nurse practitioner had a lot to do with the resident receiving the surgery. The DON was not aware of the colonoscopy appointment in [DATE] and if there would be an issue with the resident giving consent. That would be the physician's determination. If they had a resident that could no longer make decisions, they would go through the Ombudsman. There is a lot of legal ramifications to make decisions for a resident. The DON was not aware of the process of how to obtain guardianship if a resident could not make decisions and did not have family. She was not aware that the Social Services Director did not know the process. The DON said she would have to follow up with the social services director and the administrator to get more information. 2. Review of Resident #144's significant change MDS, dated [DATE], showed: -Severe cognitive impairment; -Poor appetite for ,d+[DATE] days; -No behaviors; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Total staff dependence for hygiene, toileting and eating; -Diagnoses: high blood pressure, diabetes, Alzheimer's disease, anxiety and depression. Review of the resident's progress notes, showed: -A nursing note, dated [DATE] at 8:37 P.M., audible crackles heard from the resident's bedside. Nurse Practitioner (NP) called and new orders received for a STAT complete blood count (CBC, determines general health status and screens for and monitors for a variety of disorders including anemia) and complete metabolic panel (CMP, measurement of blood sugar, electrolytes, fluid balance, kidney and liver function). Vital signs are temperature of 100.3 (normal 97.8 through 99.1), pulse 132 (normal 60 through 100), respirations 20 (normal) and blood pressure ,d+[DATE] (normal ,d+[DATE] through ,d+[DATE]); -No further nursing progress notes located to show further assessment after the resident's change in condition or further contact with the medical providers; -A nursing progress note, dated [DATE] at 8:50 A.M., the resident noted to be in his/her bed unresponsive. Upon further assessment, he/she observed to be pulseless (no pulse) and no respirations. An emergency code called per facility policy and 911 notified. Cardiopulmonary resuscitation initiated. Emergency medical services (EMS) arrived approximately 20 minutes later. Electrocardiography (ECG, monitors and records the heart rate and rhythm) attached to the resident by EMS staff. The resident noted to have no heart rhythm and had an asystole (full cardiac flat line, no heart contraction) heart pattern. The paramedic onsite called EMS dispatch and had been notified to call the resident's time of death at 8:55 A.M. The resident's guardian called and his/her family notified. The Coroner notified; -The resident's remains released to funeral home at 12:00 P.M. During an interview on [DATE] at 11:19 A.M., LPN Q said he/she had arrived at the facility to work day shift at 7:00 A.M., on the morning of [DATE]. He/she received report from the night shift nurse and the resident had been alive at that time, appeared to be normal color and had not appeared to be in distress. He/she and the night shift nurse walked the unit during report. The night shift nurse reported the resident had been ordered to receive a hospice evaluation and had received oxygen. He/she completed shift change report and began his/her medication pass at the resident's room. When he/she administered medication to the resident's roommate, he/she looked at the resident and observed the resident was not breathing. The resident had been a full code and CPR was started. The resident had expired within an hour of his/her shift starting. The resident did not have hospice evaluation orders and did not receive a hospice evaluation. There had been a chest X-ray completed and blood work, LPN Q had not been notified of any results. He/she had not notified the resident's physician of any STAT results. During an interview on [DATE] on 1:25 PM Certified Nursing Assistant (CNA) O said he/she had cared for the resident on Friday [DATE]. He/she had assisted the resident with his/her breakfast and lunch. The resident ate in the dining room and sat in his/her Geri-chair (medical reclining chair). The resident did not have any issues with swallowing or coughing. No abnormal behaviors. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:28 P.M., the DON said the resident had been a full code. If the staff note a change in condition, she expected the nurses to provide frequent assessments and document assessments in the resident's medical record at least every two hours. The nurses should have notified the physician of additional changes and the ordered laboratory values. The facility received the ordered blood work late and the resident had expired before the staff could notify the physician. The facility provided in-servicing to all the nurses regarding when a resident experienced a change in condition. There should have been more nursing notes regarding assessments from the time of discovery to the time of the resident's death. 36151 37672

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 35394 Based on observation, interview and record review, the facility failed to ensure residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing for two residents (Resident #40 and #118). This resulted in tissue decline and larger measurements of a pressure ulcer for one resident when he/she readmitted from the hospital and the facility failed to obtain treatment orders and assess the wound for two days. The facility identified four residents as having pressure ulcers, two were included in the sample of 29 and issues were found with both. The census was 146. Review of the facility's Skin Ulcer-Wound policy, dated 8/15/18, showed: -All caregivers are responsible for preventing, caring for and providing treatment for skin ulcerations; -Licenses staff will, upon admission, perform a head to toe body audit within 2 hours of admission. The findings will be documented in the resident's clinical record; -Licensed staff members will, upon admission, complete a risk scale weekly for the first four weeks and after admission for each resident at risk, then quarterly, or whenever there is a change in condition; -Licensed staff will complete a head to toe skin assessment weekly and as needed; -Staff will institute a plan for any resident who has potential for skin breakdown or whose condition is deteriorating, this may include: Turn and reposition every two hours as appropriate, pressure reduction surfaces for beds and wheelchairs, promotion of clean/dry/well moisturized skin. 1. Review of Resident #40's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/15/19, showed: -Severe cognitive impairment; -Diagnosis included cancer, diabetes, and non-Alzheimer's Dementia; -Extensive assistance with bed mobility, transfers, dressing, eating, toileting and hygiene; -At risk for pressure ulcers (injury to the skin and/or underlying tissue, as a result of pressure or friction); -No pressure ulcers at time of admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Braden assessments (assessment used to determine risk for pressure ulcers), dated 9/8/19 and 12/16/19, showed the following: -On 9/18/19, a score of 17, at risk; -On 12/16/19, a score of 8, very high risk. Review of the resident's electronic physician order sheet (ePOS), showed an order dated 12/7/19, for Duoderm (occlusive dressing) dressing. Apply to coccyx (tail bone) topically one time a day every three days. Review of the resident's care plan, dated 10/10/19 and in use during the survey, showed no documentation of the resident's pressure ulcer, interventions, goals, or stage of the pressure ulcer. Review of the resident's progress notes, dated 12/1/19 through 12/12/19, showed no documentation of the resident's pressure ulcer. Review of the facility's weekly wound report, dated 12/6/19 through 12/12/19, showed the following: -Onset date: 12/9/19; -Stage: Stage II (a partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough (dead tissue), may also present as an intact or open/ruptured blister); -New Measurements: -Length: 0.4 centimeter (cm); -Width: 0.5 cm; -Depth: 0.1 cm; -Cite: coccyx; -Acquired: In-house; -Treatment: Duoderm, change every three days and as needed. Review of the resident's treatment administration record (TAR), dated 12/1/19 through 12/12/19, showed: -On 12/9/19, the order for Duoderm dressing, apply to the coccyx one time a day every three days: Blank; -On 12/12/19, the order for Duoderm dressing, apply to the coccyx one time a day every three days, documented as administered as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's hospital record, dated 12/12/19, showed: -admitted to the hospital on 12/12/19; -Active pressure ulcer sacrum (tail bone area): Assessment date 12/12/19; -Present on admission: Yes; -Wound measurement to sacrum on 12/12/19: -Length: 4.5 cm; -Width: 5 cm; -Depth: 0.2 cm; -discharged from the hospital on 12/16/19. Review of the resident's medical record, showed the resident readmitted to the facility on [DATE]. Further review of the resident's ePOS, showed: -An order dated 12/18/19, for Venelex Ointment ([NAME]-[NAME] Oil). Apply to sacrum topically every day shift, every two days for pressure ulcer. Clean with normal saline or wound cleaner, skin prep (protective barrier wipe) to periwound (intact skin around wound edges), apply Venelex ointment to wound bed and cover with foam dressing and apply to sacrum topically as needed for pressure ulcer; -An order dated 12/18/19, for foam Dressing Bordered Pad (wound dressings). Apply to sacrum topically every day shift, every two days for pressure ulcer after skin prepping and applying Venelex and apply to sacrum topically as needed for pressure ulcer. Review of the resident's progress notes, dated 12/18/19 at 12:12 P.M., showed staff and hospice nurse at bedside for evaluation and treatment of sacral wound. Area measured approximately 5.8 cm by 6.0 cm by 0. 2 cm. Periwound macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture) and denuded skin (loss of the epidermis (top layer of skin), caused by exposure to urine, feces, body fluids) noted. Hospice nurse and nurse practitioner (NP) agreed on treatment plan change due to decline to tissue and larger measurement. Venelex and foam dressing, change every two days and as needed, noted and implemented. Further review of the resident's medical record, showed physician orders and assessments of the pressure ulcer were not obtained until 12/18/19. Further review of the resident's TAR, dated 12/16/19 through 12/31/19, showed: -On 12/18/19 and 12/20/19, foam Dressing Bordered Pad, apply to sacrum topically every day shift, every two days: blank. Not documented as applied until 12/22/19; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 12/18/19 and 12/20/19, Venelex Ointment, apply to sacrum topically every day shift, every two days: blank. Not documented as applied until 12/22/19; -No documentation of any wound treatment applied to the sacrum/coccyx area after readmission on 12/16/19 until 12/22/19. During an interview on 12/19/19 at 2:40 P.M., Licensed Practical Nurse (LPN) N said the pressure ulcer was found somewhere between 12/7/19 through 12/20/19. It was before he/she went to the hospital and the treatment order came soon after it was discovered. During an interview on 12/20/19 at 5:26 P.M., the DON said she would expect there to be documentation of the resident's pressure ulcer. She would expect staff to follow physician's orders. The resident's care plan is expected to be updated to include the pressure ulcer, measurements, and treatments. 2. Review of Resident 118's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Two staff person assist for activities of daily living; -Upper/lower extremity impairment of both sides; -Wheelchair for mobility; -One Stage III pressure ulcer; -One unstageable pressure ulcer (depth of the wound is unable to be determined); -Diagnoses included quadriplegia (paralysis of all four limbs), multiple sclerosis, (MS, disease in which the immune system eats away at the protective covering of nerves), heart failure, high blood pressure, kidney failure and diabetes. Further review of the resident's MDS records, showed: -discharge date of [DATE]; -Entry date of 11/30/19. Review of the resident's Braden assessments, showed the following: -On 5/20/19, a score of 14, moderate risk; -On 11/11/19, a score of 15, at risk; -On 11/30/19, a score of 13, moderate risk. Review of the resident's ePOS, showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-An order dated 6/14/17, for a low air loss mattress for pressure prevention; -An order dated 12/2/19 for Santyl ointment (a debriding ointment, the medical removal of dead, damaged, or infected tissue), 250 unit/gram. Apply to right ischium (area of the skin where the leg connects to the buttocks) topically every night shift for wound care. Clean with normal saline or wound cleaner. Apply Santyl ointment, nickel thick, pack lightly with calcium alginate (absorbent product) and cover with dry dressing; -An order dated 12/11/19, for Santyl ointment (a debriding ointment, the medical removal of dead, damaged, or infected tissue), 250 unit/gram. Apply to left ischium topically every night shift for wound care. Clean with normal saline or wound cleaner. Apply Santyl ointment, nickel thick, pack lightly with calcium alginate and cover with dry dressing. Review of the resident's care plan, in use during the survey, showed: -Problem: Resident has a history of having a healed unstageable pressure ulcer to the right ischium. He/she is at risk for developing other pressure related areas due to refusing to offload the area, incontinent of bowel and requiring assistance with turning and repositioning while in bed. He/she refuses to return to bed once he/she gets up into the motorized wheelchair and stays up for prolonged periods of time. On 10/15/19, stage II ulcer to right ischium; -Approach: Skin will remain intact through review date. Inform resident/family/caregivers and physician of any new area of skin breakdown. Instruct/assist him/her with shifting his/her weight in wheelchair on a frequent basis. Needs monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Monitor/document/report as needed any changes in skin status. Treatment to right ischium as ordered, inform physician if treatment plan is unsuccessful; -Further review of the care plan, showed the care plan not updated with a pressure area to left ischium. Review of the resident's wound analysis report, right ischial, showed: -On 12/4/19, (length, width, depth) 1.3 cm, 1 cm, 1.1 cm, stage III pressure injury; -On 12/11/19, 1 cm, 1 cm, 0.7 cm, stage III pressure injury; -On 12/18/19, 0.8 cm, 1 cm, 0.5 cm, stage III pressure injury. Review of the resident's wound analysis report, left ischial, showed: -On 12/4/19, 2.5 cm, 2.5 cm, 0.4, unstageable due to non-removable dressing/device; -On 12/11/19, 3 cm, 2.5 cm, 0.6 cm, unstageable due to non-removable dressing/device; -On 12/18/19, 3.5 cm, 2.7 cm, 0.8 cm, stage III pressure Injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/18/19 at 11:45 A.M., Nurse Practitioner W said the resident was hospitalized on [DATE] and returned with a worsened wound from the hospital. He/she went from a stage II to a stage III. The area on his/her left side worsened. Observation on 12/19/19 at 7:57 A.M., showed LPN N complete a dressing change for Resident #118. LPN N said he/she was the treatment nurse for the building. The resident's air mattress alarmed, turned off and then immediately kicked back on. The resident said this happens, there is a short. Staff have to come back in to fix it when it turns off. Observation of the front control panel of the air mattress, showed three buttons cracked through the plastic cover and exposed the inner workings of the machine. Certified Nurse Assistant (CNA) K assisted LPN N to reposition the resident to the left side. A brown substance visible on the outside of the dressing on the resident's left ischium and bowel movement visible on the resident's buttocks. LPN N removed the soiled dressing. He/she removed his/her gloves, washed his/her hands and went to the treatment cart. He/she mixed Santyl and collagen together in a medication cup and obtained a boarder dressing, gauze and wound cleanser. LPN N washed his/her hands and applied gloves. Wound bed yellow and pink in color. LPN N cleansed the wound with wound cleanser. Bowel movement continued to be visible on the resident's buttocks. LPN N applied the collagen and Santyl mix to the wound bed with an applicator. He/she removed his/her gloves, washed his/her hands, dated the border dressing, applied gloves and placed the dressing on the wound to the resident's left ischium. Bowel movement continued to be on the resident's buttocks. The air mattress turned off again. The resident said LPN N must have hit the cord, so the air mattress turned off. The resident's air mattress had gone flat. LPN N adjusted the electrical cord and the air mattress turned back on. The resident said the bed does this at times, ever since he/she got it. CNA K said the dysfunction of the air mattress might happen at night and no one would know. As staff assisted the resident to reposition in bed, the bowel movement fell out of the resident's rectum and fell on to the bed. Staff cleansed the resident's buttocks, assisted the resident to get positioned in bed and prepared to get the resident up for breakfast. During an interview on 12/20/19 at 4:02 P.M., the resident said if you bump the bed, it will deflate. The bed stayed deflated as long as thirty minutes at a time, and it is very uncomfortable when the bed deflated. During an interview on 12/20/19 at 4:07 P.M., LPN UU said he/she was aware the bed deflates when the plug is bumped. During an interview on 12/20/19 at 3:11 P.M., the Maintenance Director said any staff person can report an environment concern to maintenance. Maintenance staff complete room audit check sheets periodically. The sheets were part of the Quality Assurance and Performance Improvement (QAPI) plan. He would expect staff to report issues with an air mattress. Maintenance was not aware of the issue. No staff reported this issue as of this time. During an interview on 12/19/19 at 4:10 P.M., the DON said when the resident's bed gets pushed against the wall and the bed hits the plug, it deflates, LPN N is part of the wound team, is aware of the settings on the air mattress and if the bed is functioning as it should. On 12/20/19 at 2:36 P.M., the DON said if a resident had bowel movement on his/her buttocks during a treatment, she would expect it be cleaned prior to applying the new treatment. 36151

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36151 Based on interview and record review, the facility failed to follow the facility policy and the resident's care plan to prevent one resident (Resident #21) from falling during a staff assisted transfer. The sample was 29. The census was 146. Review of the facility accidents and incidents policy, dated May 15, 2019, showed: -All incidents and accidents occurring at the facility reported, investigated and tracked in accordance with the guidelines contained herein. Reports of findings will be forwarded to the Director of Nursing (DON) and/or Administrator; -Care plan revision: The safety committee will review the incident report and preliminary investigation and implement new interventions. If a fall event continues despite new interventions, analysis will be performed to determine the appropriateness of current interventions. Ensure any new interventions have been entered on the resident's care plan. Review of Resident #21's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/9/19, showed: -Cognitively intact; -Assistance of one staff for bed mobility and dressing; -Assistance of two staff for transfers and toileting; -Upper/lower extremity impairment on one side; -Wheelchair for mobility; -Diagnoses included stroke, seizure disorder, high blood pressure, diabetes and anemia. Review of the resident's nurse's note, dated 11/17/2019 at 10:30 P.M., showed a nurse assistant put resident to bed at 9:00 P.M. He/she slid from the end of the bed, and the nurse assistant held resident as he/she slid down with him/her to keep him/her from hurting him/herself. Resident stated he/she was not hurt, just slid to the floor. Resident was uninjured during this time. Resident alert and orientated. Review of the resident's care plan, in use during the survey, showed: -Problem: At risk for falls due to seizure, spastic movements, non-ambulatory, and decreased cognitive skills. History of left sided weakness. Fall on 9/13/19, noted on floor in shower room, attempted to transfer self from toilet. On 9/29/19, fell during transfer of one staff, no injuries; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Approaches: The resident will not sustain serious injury through the review date. The resident will be free of injury due to falls. Continue to educate/re-educate staff on proper transfers of two person assist. Continuous staff education on safe transfers. Educate on importance of waiting for assistance with transfers. Educate staff to use two persons to transfer resident. Educate staff to lock wheelchair prior to transfer. Educate staff on transfer with gait belt and resident requires two person transfer; -The care plan not updated with current fall, 11/17/19. During an interview on 12/19/19 at 10:08 A.M., the DON said she did not have an investigation into the resident's fall. The incident happened on the evening shift, around 9:00 P.M., the certified nursing assistant (CNA) was a new employee. The CNA was educated that the resident is a two person assist. The DON said she was unsure if the CNA used a gait belt during the transfer. She would expect new employees to ask and/or reference the resident's care card if not familiar with the resident's transfer status.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35394 Based on observation, interview and record review, the facility failed to maintain proper placement of a urinary catheter (a tube inserted into the bladder for purpose of urine drainage) and position of the catheter tubing. In addition, the facility failed to obtain orders for the catheter size. The facility identified three residents as having urinary catheters, two were included in the sample of 29 and issues were identified with one (Resident #40). The census was 146. Review of Resident #40's admission Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 9/15/19, showed: -A Brief Interview for Mental Status (BIMS) score of 3 out of 15, shows severe cognitive impairment; -Diagnoses included cancer, neurogenic bladder (the bladder does not empty urine properly due to a neurological condition), diabetes, and non-Alzheimer's Dementia; -Extensive assistance required for bed mobility, transfers, dressing, eating, toileting and hygiene; -Has a catheter. Review of the resident's electronic physician order sheet, showed: -An order dated 9/26/19, to cleanse the suprapubic catheter (urinary catheter inserted through the abdominal wall) site daily with normal saline or wound cleanser. Place drain sponge around area and secure daily; -An order dated 10/10/19, to flush the suprapubic catheter daily with sterile water, 30 milliliter (ml) every day shift for irrigation; -An order dated 10/17/19, to change the suprapubic catheter every three weeks; -No orders for the French (size) and balloon size (portion of the catheter inflated to keep the catheter in the bladder). Review of the resident's care plan, dated 10/10/19, and in use during the survey, showed no documentation of the resident's catheter, interventions, and goals. Review of the resident's treatment administration record, dated 12/1/19 through 12/23/19, showed: -Staff documented a treatment to cleanse suprapubic catheter site daily with normal saline or wound cleanser every night shift on the following dates and times: On 12/2, 12/5, 12/6, 12/10, 12/16, 12/18, 12/19, and 12/20/19; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff documented the changing of the suprapubic catheter on 12/19/19; -The order to flush the suprapubic catheter daily with sterile water, 30 ml every day shift, not documented. Observation and interview, showed: -On 12/19/19 at 6:41 A.M., the resident in bed with eyes closed and the catheter on the left side of the bed with the drainage bag inside a privacy bag. At 2:34 P.M., the catheter tubing lay on the floor with approximately 24 inches of dark yellow inside the tube that did not drain. Certified Nurse Aide (CNA) DD entered the resident's room, but did not assess the catheter tubing on the floor; -On 12/20/19 at 7:30 A.M., CNA DD assisted the resident with his/her meal. The resident lay in bed with the head of bed up. The catheter tubing lay on the floor with approximately 24 inches of amber colored urine in the tube that did not drain. At 11:49 A.M., the resident lay in bed with his/her eyes closed. The catheter tubing lay on the floor with approximately 24 inches of urine in the tube. During an interview on 12/18/19 at 11:36 A.M., the resident's family member said there was an infection in the catheter. There was an odor and the resident was on antibiotics for it. During an interview on 12/19/19 at 2:40 P.M., Licensed Practical Nurse (LPN) N said the resident's catheter would get clogged with sediment and the urine was always on the darker side. He/she had one urinary tract infection (UTI) since he/she was admitted . He/she was sent out to the hospital. LPN N was unsure when the resident was sent to the hospital. During an interview on 12/20/19 at 5:26 P.M., the Director of Nursing said she would expect the resident to have complete orders for the catheter, including the French and balloon size. She would expect staff to ensure the resident's catheter tubing and drainage bag is below the bladder, and the tubing is straight so the urine can completely drain, and not on the floor due to infection control.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility failed to communicate weight loss with the registered dietician (RD), obtain weights as ordered and ensure residents had physician ordered diets for four residents (Residents #106, #69, #77 and #50). The sample size was 29. The census was 146. Review of the facility's Nutrition and Unplanned Weight Loss/Gain Policy, dated 6/28/19, showed the following: -The facility will assess and monitor the nutritional status of the residents to assist in maintaining adequate nutritional status, to the extent possible, giving careful consideration to the following: The resident's choice to make informed decisions, the resident's nutritional and hydration needs, and by considering any physiological or functional impairments which may need to be addresses; -Guidelines: All residents shall be weighed upon admission, monthly, and as required by their clinical condition, and/or the discretion of weighing residents as often as is required by the resident's clinical condition. Indications that would prompt more frequent weight measurements; -Weekly weights should occur: with significant weight loss or gain; -The nutritional committee, Medical Doctor and RD will determine when weekly weights may be discontinued based on individual resident needs or condition; -Monthly weights should be obtained no later than the 7th day of each month. Weekly weights should be obtained, when possible, on the same day and the same approximate time to prevent drastic changes; -The director of nursing and his/her designee will review all weights for accuracy and will, when necessary, assign reweights; -Weights are recorded in the electronic medical record by the 15th of the month; -The physician and the resident's responsible party will be notified of any significant weight changes and the need for modification of the resident nutritional regimen within 72 hours of the identification of a significant loss or gain; -The RD is responsible to complete an assessment; estimating calorie, nutrient and fluid needs of all residents upon admission, annually, and as needed. Nursing is responsible to ensure all needed information is submitted to the RD. 1. Review of Resident # 106's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, dated 10/30/19, showed the following: -Severe cognitive impairment; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Signs and symptoms of possible swallowing disorders: None; -Weight loss of 5% or more in the last month or 10% or more in the last six months: No or unknown; -Nutritional approach: None; -Dental section: Blank; -Eating: set up and supervision only; -Diagnoses included: high blood pressure, ulcerative colitis (chronic, inflammatory bowel disease that causes inflammation in the digestive tract), high cholesterol, dementia, Parkinson's disease (a disorder of the brain that leads to tremors, difficulty with walking, movement and coordination), manic depression (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), psychotic disorder (disorder characterized by a disconnection from reality) and schizophrenia (long-term mental disorder, involving a breakdown in the relation between thought, emotion and behavior). Review of the resident's monthly weights from June through December 2019, showed: -On 6/7/19, weight 191.4 pounds (LBS); -On 8/8/19, weight 196 LBS; -On 11/8/19 weight 173.8 LBS; -On 11/19/19 weight 175.8 LBS; -On 11/25/19 weight 174.9 LBS; -On 12/2/19 weight 168 LBS; -The documentation of the weight of 191.4 LBS in June and the weight of 168 LBS in December showed a significant weight loss of 12.23% in six months. Review of the resident's dietary notes, dated 8/12/19, showed: -Residents weight on 8/6/19, documented as 196 LBS; -Diet is regular; -Summary: The resident's by mouth intake has been good; weight has been stable over the last year. The resident is alert and able to consume his/her meals independently. May require altered texture diet with disease progression; -Continue regular diet; monitor chewing and swallowing. -No other RD notes documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's electronic physician order sheet (ePOS), showed: -Ensure Liquid (Nutritional Supplements) Give 240 milliliters (mL) by mouth after meals for weight loss; -An order dated 11/18/19, for weekly weights, weight every Monday related to mild protein-calorie malnutrition; -Ready Care 2.0 (nutritional supplement) three times a day related to mild protein-calorie malnutrition; -Scopolamine (used to treat nausea) base patch 72 Hour 1.5 mg, apply 1 patch transdermal (on the skin) one time a day every 3 days for nausea and vomiting/excessive secretions; -Diet: Regular texture, regular consistency. Review of the resident's weekly weights, showed the weekly weights for the weeks of 12/9/19 and 12/16/19, not documented. Observation of the resident during the survey, showed: -On 12/17/19 at 1:00 P.M., the resident sat in his/her wheelchair at the dining room table. The staff served the resident a regular diet. The resident fed him/herself. The resident ate well for lunch; -On 12/19/19 at 6:00 P.M., the resident sat at the dining room table. The staff served the resident apple sauce, hamburger helper, salad, lemon-aid and coffee. The resident fed him/herself. The resident ate well. After dinner, Licensed Practical Nurse (LPN) N gave the resident one bottle of Ensure. The resident took the Ensure back to his/her room to drink. Review of the resident's comprehensive care plan, in use at the time of survey, showed: -Problem: The resident consumes a mechanical soft diet; -Goal: The resident will not have signs and symptoms of aspiration. Weight to remain stable thru next review; -Interventions: Diet as ordered. Dietician to evaluate as needed. Monitor weight monthly and as needed. Inform the medical doctor of significant weight changes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/19 at 1:30 P.M., LPN Q said if a resident's weight goes up or down, the facility would get an order for a dietary consult. If a resident has weight loss, staff usually get an order for a supplement. The dietician visits monthly. If the dietician recommends an intervention for a resident, the dietician would give the recommendations to the Director of Nursing (DON), then the DON would notify the MDS nurse, then the floor manager would be notified, then the charge nurse on the unit would be notified. The MDS nurse usually puts the orders in the computer, but sometimes the nurse on the floor will put the order into the computer. The facility has a daily clinical meeting with licensed staff and discuss what is going on with residents, like weight loss. The clinical meetings are held all three shifts and weekends. All the residents get a monthly weight. Nurse Practitioner W will give an order for weekly weights. Weekly weights are documented on the medication administration record (MAR), and/or under the Vital Signs (VS) tab in the electronic medical record. During an interview on 12/20/19 at 6:30 P.M., the DON said the RD should have been notified of the significant weight loss and the RD recommendations should have been followed. The DON said the RD would give the DON a report, then the DON gives the report to Assistant Director of Nursing (ADON) A. ADON A would ensure the orders are carried out. During an interview on 12/23/19 at 11:30 A.M., the DON said she did review the resident's record for weight loss, the resident was on a hunger strike. Further review of the resident's care plan, showed no documentation of the resident's hunger strike with goals and interventions. 2. Review of Resident #69's quarterly MDS, dated [DATE], showed; -Cognitively intact; -One person assist with activities of daily living; -Wheelchair for mobility; -Diagnoses included cancer, hepatitis and malnutrition/at risk. Review of the resident's ePOS, showed an order dated 7/11/19, for regular diet, regular texture, and regular consistency. Mighty Shake (caloric and protein supplement) with meals. Review of the resident's care plan, in use during the survey, showed: -Problem: Resident has had significant weight loss diagnosis with severe protein calorie malnutrition, is at risk for further weight loss due to diagnosis of liver cell carcinoma (cancer); -Approach: Resident will have adequate food/fluid intake thru next review. Monitor for decline in appetite and health. Provide and serve diet as ordered. Review of the resident's monthly weights for 2019, showed: -On 7/9/19, 151.7 LBS; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/16/19, 148 LBS; -On 9/16/19 140.6 LBS. Review of the RD note, dated 9/30/19, showed current weight of 140.6 LBS; August weight not available. A 20.7 LBS significant weight loss x 3 months. Recommend Mighty Shake with each meal for additional support. Further review of the resident's monthly weights for 2019, showed: -On 10/6/19, 140.8 LBS; -On 11/8/19, 133.8 LBS; Review of the RD note, dated 11/15/19, showed weight recorded as 133.8 LBS, another 7# loss x 1 month. Resident continues on a regular diet with reasonably good appetite. He/she remains on Hospice. Recommend Mighty Shake with each meal as decreased appetite anticipated. Further review of the resident's monthly weights for 2019, showed: -On 12/8/19, 136.2 LBS; -The documentation of the weight of 151.7 LBS in July and the weight of 136.2 LBS in December, showed a weight loss of 10.22% for 5 months. During an interview on 12/20/19 at 9:14 A.M., Certified Nursing Assistant (CNA) SS said the resident ate pretty well, he/she doesn't like eggs, so he/she won't eat them, but he/she ate everything else. During an interview on 12/20/19 at 9:16 A.M., CNA TT said the resident will eat what he/she likes, he/she does not like health shakes and won't drink them. During an interview on 12/20/19 at 5:35 P.M., the DON said she would expect staff to relay likes and dislikes to the RD, so he/she could add supplements to the resident's diet that he/she would like. 3. Review of Resident #77's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included diabetes, high blood pressure, dementia, depression and asthma; -Supervision with eating; -Weight loss of 5% or more in the last month or 10% or more in the last six months: No or unknown; -Weighs 220 LBS. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 10/24/19, showed: -Focus: Resident has actual nutritional risk related diagnoses of diabetes, stroke, depression, the use of psychotropic and impaired cognition; -Interventions: Provide and serve diet as ordered. RD to evaluate and make diet change recommendations as needed. Review of the resident's dietician progress note, dated 7/8/19, showed: -Nutritional plan: Continue Regular diet; -Nutritional summary: Resident appears well nourished. He/she is alert and independent with his/her meals; has demonstrated a good appetite since admission. Weight indicated obesity. There are no chewing or swallowing concerns; skin is intact. Blood sugar has been in fair control. Goal = stable weight and blood sugar. Review of the resident's ePOS, showed: -An order dated 10/12/19, for weights, check and record monthly; -An order dated 12/20/19, for regular diet, regular texture, and regular consistency. Review of the resident's monthly weight record, showed: -On 9/16/19: 230.0 LBS; -On 10/8/19: 219.8 LBS; -On 12/4/19: 211.6 LBS; -Indicated a significant weight loss of 8% in three months. Review of the resident's medical record, showed no RD documentation regarding the resident's significant weight loss. Observation of the resident, showed: -On 12/18/19 at 8:23 A.M., staff served the resident scrambled eggs, cereal, and toast that were regular texture. The resident was able to consume the meal independently; -On 12/18/19 at 12:40 P.M., the resident sat in the dining room with one table mate. Staff served the resident his/her regular diet; -On 12/20/19 at 12:48 P.M., staff served the resident his/her meal, shrimp served on a bed of long strands of pasta and broccoli. Resident ate the meal independently. 4. Review of Resident #50's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively intact; -Resident eats independently with no set up; -Diagnosis included: high blood pressure, low sodium levels, seizures and schizophrenia. Review of the resident's ePOS, showed: -No order for a diet as of 12/19/19; -On 12/20/19,an order for a regular diet had been entered into the electronic medical record. Review of the resident's dietary note, date 1/17/19, showed: -Diet: regular; -Nutritional Summary: Resident is tolerating mechanical soft and intake has been good. Sodium levels tend to run low. Current weight is consistent with weight one year ago. Continue current plan; -Nutritional Plan: Continue mechanical soft diet. Observation of the resident during survey, showed the following: -On 12/17/19 at 1:00 P.M., the resident sat at the dining room table and fed him/herself. The resident ate 100% of a regular diet. The menu was creamy chicken, carrots, bread stick, red velvet cake, lemon-aid and coffee; -On 12/19/19 at 6:00 P.M., the resident sat in the dining room and fed him/herself. The resident ate well. The resident ate applesauce, hamburger helper and a sandwich. He/she drank lemon-aid and coffee. Review of the resident's diet card, reviewed on 12/20/19 at 3:00 P.M., showed regular diet with regular liquids. Review of the resident's care plan, in use during survey, showed: -Problem: The resident is edentulous (not having teeth); Goal: Maintain current level of function with eating, and will not show signs and symptoms of malnutrition; -Interventions: Speech therapy consulted and regular diet approved. During an interview on 12/20/19 at 1:30 P.M., the dietary manager said the following: -The resident is on a regular diet and sometimes he/she will eat a pureed diet, when he/she chooses; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When the doctor or RD give an order for dietary orders, the nurse writes the order on a carbon copy paper and gives the order to dietary department; -If the RD is in the facility, the RD will tell the dietary manager of any changes or recommendations he/she is making; -Sometimes the RD will email the dietary manager with new orders. 5. During an interview on 12/20/19 at 5:20 P.M., the Director of Nursing (DON) said if there is an RD recommendation, it is discussed with the DON. The DON gives a written report to the ADON to ensure the orders are carried out. The DON would expect all residents to have dietary orders. Staff are expected to report weight loss to her and the registered dietician. 36151 42247

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on observation, interview and record review, the facility failed to provide thorough assessments, on-going monitoring and communication with the dialysis center. In addition, the facility failed to have a policy to address the assessments, monitoring and communication with dialysis centers for their dialysis residents. The facility identified five residents who receive dialysis. Of those five, three were included in the sample of 29 and concerns were identified with two (Residents #64 and #43). The census was 149. During an interview on 12/23/19 at 12:14 P.M., the Director of Nursing (DON) said the facility does not have a dialysis (process of filtering toxins from the blood in individuals with kidney failure) policy. The pre and post dialysis assessments are scanned into the system. They are still working on scanning the assessments for December. 1. Review of Resident #64's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/3/19, showed: -The resident received dialysis; -Diagnoses included kidney failure. Review of the facility's dialysis schedule for all residents on dialysis, showed the resident attended dialysis on Monday, Wednesday and Friday. Review of the resident's dialysis assessments for Mondays, Wednesdays and Fridays in November 2019, showed: -On 11/1/19, no pre or post dialysis assessment completed; -On 11/4/19, no post dialysis assessment completed; -On 11/6/19, no post dialysis assessment completed; -On 11/8/19, no pre or post dialysis assessment completed; -On 11/11/19, no post dialysis assessment completed. Review of the resident's progress notes for November 2019, showed no pre or post dialysis assessments documented on 11/1, 11/4, 11/6, 11/8 and 11/11/19. Review of the resident's care plan, in use at the time of the survey, showed: -The resident needs dialysis; -The resident has diagnosis of end stage kidney disease, he/she receives dialysis three times weekly, is at risk for weight variances, fluid electrolyte imbalance, dehydration; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident will not have signs and symptoms of dehydration/fluid overload or of complications to dialysis shunt (dialysis access site); -Check and change dressing daily at access site. Document; -Do not draw blood or take blood pressure in arm with shunt; -Monitor weight monthly/as needed; -Send or fax dialysis communication form with resident. Review of the resident's electronic physician order sheet (ePOS), showed: -An order dated 12/11/18, for regular diet, regular texture, regular consistency, no oranges, no orange juice, no tomatoes or tomato products, no bananas, may have potatoes two times weekly related dialysis, sack lunch provided on dialysis days for diet; -An order dated 6/2/19, to check fistula (dialysis access site) for thrill and bruit (the sound you hear and vibration you feel at the dialysis access site) to left upper arm every shift for dialysis access; -An order dated 9/27/19, for the dialysis company, transportation via transport company; -The order did not identify how many times a week the resident attends dialysis or what days the resident attends dialysis; -No order for check and change dressing at access site. During an observation and interview on 12/17/19 at 2:12 P.M., the resident said he/she receives dialysis. Observation of the resident's left outer/upper arm, showed a bandage. The resident said the bandage covers his/her dialysis shunt. 2. Review of Resident #43's quarterly MDS, dated [DATE], showed; -Moderate cognitive impairment; -Extensive staff assistance with hygiene, dressing and transfers; -Diagnoses of anemia, high blood pressure, dementia, seizure and kidney disease. Review of the resident's care plan, in use at the time of the survey, showed: -Focus: The resident received dialysis treatment three days a week. The dialysis shunt is located in the left upper arm; -Goal: The resident will have no signs or symptoms of bleeding or infection to the dialysis shunt site; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: No blood draws will be taken from the left arm, monitor the resident for signs and symptoms of bleeding and swelling, staff to monitor and report lab results to the physician. Review of the resident's ePOS, showed: -An order dated 6/4/19, to check and record weight before dialysis and check vital signs before and after dialysis every Tuesday, Thursday and Saturday; -No orders noted to assess the dialysis access site for bleeding, bruit or thrill. Review of the resident's treatment administration record (TAR), dated 11/1/19 through 11/30/19, showed no dialysis shunt site assessment ordered. Review of the resident's dialysis communication record, showed: -On 11/2/19, a pre dialysis weight and vital sign assessment completed by the facility, showed the right chest wall site intact. An assessment was done while at the dialysis center by the dialysis staff; -No pre dialysis weight, vital sign assessment communication noted for 11/5/19 or 11/7/19; -On 11/9/19, a pre dialysis weight and vital sign assessment completed by the facility and an assessment completed by the dialysis staff, showed an intact right chest wall access site; -An incomplete post dialysis communication form, dated 11/12/19; -A completed pre and post dialysis communication form dated 11/14/19; -No communication forms noted for 11/16/19 or 11/18/19; -A communication form dated 11/21/19, completed for pre dialysis included vital signs and the resident's weight. The form contained no onsite dialysis or post dialysis communication to the right chest wall; -No communication forms noted for 11/23/19, 11/26/19 or 11/30/19. Review of the progress notes, showed: -On 12/12/19 at 2:44 P.M., the resident returned from dialysis treatment. Vital signs and weight taken. The left upper arm dialysis shunt is positive for bruit and thrill. The resident is alert/oriented to person, place and reports having no pain or discomfort at this time; -On 12/13/19 at 3:42 P.M., the resident returned from dialysis, observed a small amount of bleeding to the old shunt site to the left upper arm. The resident cannot recall what caused the bleeding, but denied any pain or discomfort. Applied a dry dressing and compression wrap. Notified the Nurse Practitioner (NP) and no new orders noted. Will continue to monitor. (No further assessments or documentation noted regarding bleeding); (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/14/19 at 2:55 P.M., the resident arrived back from dialysis. No complaints of pain or discomfort. Vital signs stable, no bleeding noted to left shunt, dressing intact. Port dressing intact to the left chest. If the left arm access starts to bleed, send to the emergency room per the dialysis clinic. Resident is currently with his/her spouse. Will return tomorrow, meds sent; -On 12/17/19 at 11:45 A.M., the resident returned from dialysis. Vital signs stable. Left upper extremity shunt cite clogged. The resident has a right chest wall access site in place. No redness or swelling noted to chest wall site; -On 12/19/19 at 11:19 A.M., the resident returned from dialysis and his/her vital signs noted to be stable. The left upper extremity shunt site remained clogged and the right chest wall site noted to be intact. 3. During an interview on 12/20/19 at 5:27 P.M., the DON said she would expect staff check the bruit and thrill as ordered. This should be documented. She did not think it was necessary to include the days the residents attend dialysis in the dialysis order. She expected the nurses to complete the post dialysis assessment. In addition, the orders should include orders to assess the bruit and thrill of the dialysis site. The access area should be monitored and assessed, because the residents receive heparin (blood thinner) at the time of dialysis and staff should be monitoring for bleeding. 35394 37672

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 32847 Based on interview and record review, the facility failed to ensure each nurse aide had no less than 12 hours of in-service education per year for four of five sampled certified nursing assistants (CNAs). The census was 146. Review of the facility's CNA training records, showed: -CNA FF: Date of hire (DOH) 11/12/01: Hours from 11/12/18 to 11/12/19 = 8.75; -CNA EE: DOH 8/15/12: Hours from 8/15/18 to 8/15/19 = 4.75; -CNA GG: DOH 5/31/17: Hours from 5/31/18 to 5/31/19 = 2.75; -CNA T: DOH 8/12/19: Hours from 8/12/18 to 8/12/19 = 10.75. During an interview on 12/20/19 at 1:18 P.M., Licensed Practical Nurse (LPN) I said he/she was the staff development coordinator. She would expect CNAs to have the required 12 hours of training per year. He/she started this position in September and has been working on catching up.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 32847 35394 Based on observation, interview and record review, the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by not providing advocacy for one resident without the capacity to consent (Resident #124). The census was 146. 1. Review of Resident #124's annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 2/6/19, showed: -Rarely understood; -Diagnoses included anemia, high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), colitis (inflammation of the colon), diabetes, non-Alzheimer's dementia, schizophrenia (severe mental disorder that affects thinking), schizoaffective disorder, restlessness and agitation; -Signs and symptoms of delirium present; -Wandering exhibited in the last 1-3 days; -Independent with bed mobility and transfers; -Supervision with dressing, eating and hygiene. Review of the resident's care plan, updated 12/17/19 and in use during the survey, showed: -Focus: Resident has impaired cognition function related to dementia: -Goal: Resident will maintain current level of cognitive function through the review date. Resident will be able to communicate basic needs on a daily basis through the review date; -Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness; -Focus: Resident has communication problem: -Goal: Resident will be able to make basic needs known; -Interventions: Encourage him/her to continue stating thoughts even if he/she is having difficulty. Focus on a word or phrase that makes sense, or respond to the feeling he/she is trying to express. Review of the resident's social service progress notes, dated 8/13/19, showed: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident is a full code. There are no plans for discharge at this time. Resident has no complaints or concerns at this time. Review of the resident's progress notes, showed: -On 8/13/19 at 3:07 P.M., care plan meeting held with Interdisciplinary Team (IDT). Resident in attendance, and is his/her own responsible party; -On 8/27/19 at 10:56 A.M., spoke to hospital staff. He/she informed facility that the resident's colonoscopy (an exam used to detect changes or abnormalities in the large intestine and rectum) scheduled for 8/22/19 was not performed due to his/her cognitive deficits. He/she was unable to tell them if he/she had drank the prep, prior to coming for the procedure, he/she could not verbalize understanding of the procedure or why it needed to be performed. Stated the resident was alert and oriented to person only. He/she also stated that he/she attempted to reach his/her emergency contacts and no one answered either number. Staff informed them that they would make Nurse Practitioner W aware of the conversation; -On 8/27/19 at 11:09 A.M., notified Nurse Practitioner W of the conversation from hospital staff. He/she stated that he/she was aware and has been unsuccessful in locating a family member to give consent for the procedure; -On 10/20/19 at 10:59 P.M., resident was noted with large bowel sitting at anal opening while lying on his/her side during Certified Nurse Aide (CNA) rounds. The bowel was the size of a baseball. No distress was noted from resident. No signs/symptoms of pain nor discomfort noted. Resident did refuse CNA assistance. This writer showered resident, provided fresh linen and encouraged fluids since bowel was noted hard and formed. Vital signs are within normal limits for this resident at this time; -On 10/21/19 at 11:00 A.M., resident received orders from Nurse Practitioner W to be discharged to the hospital for evaluation and treatment. Follow up with Hepatitis C management and overall decline; -On 10/22/19 at 2:22 P.M., received call from nurse at the hospital, making facility aware that the resident is being admitted to the hospital with a diagnosis of intussusception (obstruction resulting from the intestines telescoping on themselves) of the intestines; -No documentation social services attempted to contact the next of kin, locate an alternate family member or advocated for a representative to assist the resident with medical decision making. During an interview on 12/19/19 at 2:53 P.M., Licensed Practical Nurse (LPN) N said the resident did not receive a colonoscopy because he/she was not able to give consent to the procedure. He/she was his/her own responsible party. He/she had a family member, but they could not be reached. His/her information was also sent to the hospital and they were unsuccessful in getting information. The resident had a steady decline before October 2019 and it was hard to get to the bottom of what was going on, because he/she did not have anyone to sign for him/her. It was hard to send him/her to the hospital. He/she is a poor historian and does not have anyone to talk for him/her. Obtaining a public administrator was not that simple; however, LPN N did not know how that worked. LPN N remembered Nurse Practitioner W asked someone at the hospital regarding how they could obtain consent for the resident. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/19 at 4:00 P.M., the Director of Social Services said he/she might have heard about the resident in need of someone to consent for him/her. He/she was not aware that due to the resident not having anyone to consent for him/her, he/she was not able to proceed with the colonoscopy appointment. If a resident was able to make decisions at the time of admission and later declined and they could no longer make medical decisions, they would call the next of kin. The Director of Social Services was not aware of what the next step would be if there was a resident without a next of kin. There was only one time he/she experienced providing a resident with a POA and it was a family member in regards to a code status. He/she did not know if there was a facility policy that addressed this. He/she had never contacted a public administrator at any point since he/she had been employed with the facility, nor assisted anyone with guardianship at any point in his/her career as a social worker and did not know the process. During an interview on 12/20/19 at 9:18 A.M., Nurse Practitioner W confirmed that the resident needed the colonoscopy; however, he/she could not consent. He/she needed an acute reason to go to the hospital. The hospital was not going to keep him/her at first. He/she had a cousin that was listed, but there was no answer. That also happened at the doctor's office and at the hospital. He/she could not consent. During an interview on 12/20/19 at 5:26 P.M., the Director of Nursing (DON) said if the physician said to reach out to the family and get a guardian, or get the social worker and the Ombudsman involved to see what the options were, we would have done that. There was no sense of urgency, but there was a conversation about the issue. The nurse practitioner attended the clinical meetings and spoke with the physician about the resident. The DON was not aware of the colonoscopy appointment in January 2020 and if there would be an issue with the resident giving consent. That would be the physician's determination. If they had a resident that could no longer make decisions, they would go through the Ombudsman. There is a lot of legal ramifications to make decisions for a resident. The DON was not aware of the process of how to obtain someone with decision making capabilities if a resident could not make decisions and did not have family. She was not aware that the Social Services Director did not know the process. The DON said she would have to follow up with the social services director and the administrator to get more information. 36151

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35394 Based on interview and record review, the facility failed to ensure a resident had appropriate diagnoses for the use of psychotropic medications, for one of five residents investigated for unnecessary medication review (Resident #124). The census was 146. Review of Resident #124's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/9/19, showed: -Has delusions; -Diagnoses included anemia, high blood pressure, viral hepatitis, diabetes, non-Alzheimer's dementia, and schizophrenia (brain disorder that causes distorted thinking); -Antipsychotics and antidepressants were administered 7 of the last 7 days; -Diagnosis of depression not documented. Review of the resident's electronic medical record, showed no diagnosis of depression. Review of the resident's care plan, dated 12/17/19, and in use during the survey, showed no documentation of depression, interventions, or goals. Review of the resident's electronic physician orders sheet, showed: -An order dated 11/5/19, for Trazodone HCL (used to treat depression) tablet, 50 milligram (mg). Give 25 mg by mouth at bedtime for antidepressant; -An order dated 11/5/19, for Lexapro (used to treat depression) tablet 20 mg. Give 20 mg by mouth one time a day for antidepressant. During an interview on 12/23/19 at 11:39 A.M., the Director of Nursing (DON) said the resident's diagnosis was transcribed incorrectly on the POS. The correct diagnosis should have been coded at mood disorder.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 32847 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Out of 30 opportunities observed, two errors occurred resulting in a 6.6% error rate (Residents #394 and #129). The census was 146. 1. Review of Resident #394's electronic physician order sheet (ePOS), showed an order dated 11/26/19, for Novolog (short acting insulin). Inject as per sliding scale: If 151 to 250 = 3 units. Observation on 12/18/19 at 5:47 A.M., showed Licensed Practical Nurse (LPN) II obtained the resident's blood sugar result of 194. He/she withdrew insulin from an insulin vial into an insulin syringe and said he/she was giving 3 units. The plunger was visible at the 3 unit line, but an air bubble of approximately 1 unit visible in the syringe. He/she administered the insulin without clearing the air bubble. 2. Review of Resident #129's ePOS, showed an order dated 4/27/17, for ferrous sulfate (iron) tablet, 325 milligrams (mg). Give 1 tablet via gastric tube (tube inserted into the stomach to provide food, fluid and medications) one time a day for supplementation. Observation on 12/18/19 at 8:08 A.M., showed LPN L administered the resident's medications via gastric tube. He/she obtained a 325 mg iron tablet, crushed the tablet, mixed it with water and administered it to the resident via the gastric tube. Review of Drugs.com, last updated 4/25/19, showed ferrous sulfate is a type of iron. Swallow iron tablets and capsules whole. Do not crush, open or chew. Available in liquid form. 3. During an interview on 12/20/19 at 2:38 P.M., the Director of Nursing said medications should be administered as ordered. Staff should make sure all air bubbles are out of the syringe when administering insulin from a vial. An air bubble could affect the dose administered. Ferrous sulfate should not be crushed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 32847 Based on observation, interview and record review, the facility failed to ensure residents are free of any significant medication errors for one resident administered insulin during the medication administration observation (Resident #394). The census was 146. Review of Resident #394's electronic physician order sheet, showed an order dated 11/26/19, for Novolog (short acting insulin). Inject as per sliding scale: If 151 to 250 = 3 units. Observation on 12/18/19 at 5:47 A.M., showed Licensed Practical Nurse (LPN) II obtained the residents blood sugar result of 194. He/she withdrew insulin from an insulin vial into an insulin syringe and said he/she was giving 3 units. The plunger was visible at the 3 unit line, but an air bubble of approximately 1 unit visible in the syringe. He/she administered the insulin without clearing the air bubble. During an interview on 12/20/19 at 2:38 P.M., the Director of Nursing said medications should be administered as ordered. Staff should make sure all air bubbles are out of the syringe when administering insulin from a vial. An air bubble could affect the dose administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32847 42247 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently acceptable professional principles, by failing to ensure all controlled substances were stored under double locks and failed to ensure medications were labeled with residents name, injectable medications were dated when opened, and expired medications were disposed of. This effected two of three medication rooms and two of three medication carts reviewed. The census was 146. Review of the facility's Controlled Substance policy, dated 8/2/19, showed the following: -Policy: The facility shall attempt to comply with Federal and State laws, regulations, and other requirements related to handling, storing, disposal, and documentation of controlled substances; -Securing and storage: -The controlled substances must be stored in a locked container separate from non-controlled medications; -The controlled substances must be stored where they can be doubled locked, for example: in a locked container which is stored in a locked medication room, or in a medication cart which houses secured locked box with the medication being locked when not being directly supervised by authorized personnel. During an interview on 12/19/19 at 6:13 P.M., the administrator said the facility has no policy on medication storage. 1. Observation on 12/19/19 at 6:00 A.M., of the third floor south medication room, showed the following: -One vial of floor stock tuberculin (medication used in aiding the diagnosis of tuberculosis), opened and not dated (medication is good for 30 days after it is opened); -One Humalog (insulin) mix 75/25, opened and not dated. The medication label had a dispense date of 10/14/19; -Inside the medication refrigerator: -The door to the medication refrigerator unlocked. Inside the refrigerator, located in the door of the refrigerator, one lorazepam (narcotic medication used to treat anxiety) vial 2 milligram (mg)/milliliter (ml) injectable medication, not behind a double lock; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One carton of two percent milk; -One container of chocolate pudding; -One peanut butter and jelly sandwich; -One block of open cheddar cheese wrapped in a paper towel; -Inside the freezer portion of the refrigerator, a white Styrofoam cup with an abundance of frost that prevented the cup from being removed from the freezer. 2. Observation on 12/19/19 at 7:00 A.M., of the second floor main medication room, showed one vial of floor stock aplisol injectable (medication used in aiding the diagnosis of tuberculosis), opened and not dated. The label of the medication had a dispense date of 6/21/19. 3. Observation on 12/19/19 at 6:15 A.M., of the third floor main medication cart, showed the following: -One vial of floor stock tuberculin, open and dated 11/14/19; -One Basaglar (insulin) pen with no name on the medication and no date; -Two separate containers, each container contained three vials of Haldol injectable medication (antipsychotic medication used to treat psychotic disorders) opened and not dated. The dispense date labeled 10/14/19 and 10/26/19; -One loose vial of Haldol located in the sixth drawer of the medication cart with no name on the medication; -LPN II said he/she did not know who the medications with no name belonged to. LPN II removed the medication from the cart. 4. Observation on 12/19/19 at 7:15 A.M., of the first floor main medication room, showed one bottle of Folic Acid (B vitamin) with an expiration date of 10/19. 5. During an interview on 12/19/19 at 7:25 A.M., Licensed Practical Nurse (LPN) C said: -Controlled substances should be locked under two locks; -Medications should be dated when opened; -Stock medications are checked for expiration dates before they are put on the medication cart. During an interview on 12/19/19 at 7:30 A.M., the Director of Nursing said: -Controlled substances are to be kept under two locks; -Medications are to be dated when the medication is opened; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a medication does not have a name or date on them, the medication is discarded; -Food should not be in the medication refrigerator.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review the facility failed to ensure ordered STAT (immediate) laboratory testing had been obtained and the results received in a timely manner for one closed record resident and one sampled resident (Resident #144 and #124). The sample was 29. The census was 146. Review of the facility's laboratory service agreement between the facility and the facility's contracted Laboratory Company, dated [DATE], showed: -Testing: The laboratory shall provide collection of specimens for STAT laboratory services during regular business hours or after business hours, as well as other collections after regular business hours. STAT testing will be ordered only when medically necessary for the care of the resident and must be testing that is included on STAT eligible testing. The laboratory will typically provide STAT results within four hours of laboratory collection or pick-up. 1. Review of Resident #144's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated, [DATE], showed: -Severe cognitive impairment; -Poor appetite for ,d+[DATE] days; -No behaviors -Total staff dependence for hygiene, toileting and eating; -Diagnoses: high blood pressure, diabetes, Alzheimer's disease, anxiety and depression. Review of the resident's medical record, showed: -A progress note, dated [DATE] at 8:37 P.M., audible crackles heard from the resident's bedside. Nurse Practitioner (NP) called and new orders received for a STAT complete blood count (CBC, determines general health status and screens for and monitors for a variety of disorders including anemia) and complete metabolic panel (CMP, measurement of blood sugar, electrolytes, fluid balance, kidney and liver function). Vital signs are temperature of 100.3 (normal 97.8 through 99.1), pulse 132 (normal 60 through 100), respirations 20 (normal) and blood pressure ,d+[DATE] (normal ,d+[DATE] through ,d+[DATE]); -No further progress notes showed communication with the laboratory. Review of the resident's radiological and laboratory results, showed a STAT CMP and CBC collected on [DATE] at 2:29 A.M. No noted results within the four hour window. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes, showed on [DATE] at 8:50 A.M., the resident found in bed unresponsive and pulseless. Emergency services called and cardiopulmonary resuscitation (CPR) preformed. Emergency services on scene and the resident did not respond. Paramedic called the resident's time of death. The resident's guardian and physician notified. Further review of the laboratory results, showed the STAT CMP and CBC reported on [DATE] at 7:07 P.M. to the facility. 2. Review of Resident #124's annual MDS, dated [DATE], showed: -Rarely understood; -Diagnoses included anemia (low red blood cell count), high blood pressure, gastroesophageal reflux disease (GERD, acid reflux), colitis (inflammation of the colon), diabetes, non-Alzheimer's dementia, schizophrenia (severe mental disorder that affects thinking), restlessness and agitation; -Signs and symptoms of delirium present; -Supervision with dressing, eating, and hygiene. Review of the resident's electronic physician orders sheet (ePOS), showed an order dated [DATE], for STAT stool guaiac (lab test used to determine if there is blood in the stool), diagnosis of anemia. Review of the resident's progress notes, showed: -On [DATE] at 3:02 P.M., resident up and about on unit. Assisted with activities of daily living (ADLs). Respiration even and non-labored. Lung sounds clear. Abdomen soft and round with active bowel sounds times four quadrants. Resident informed that a stool collection is needed today. Specimen placed inside of toilet to obtain stool sample; -On [DATE] at 8:56 A.M., (23 days after the order to obtain the stool sample, ordered on [DATE] STAT) call placed to lab pending guaiac stool. He/she did not see specimen results, but will contact supervisor to see where specimen is waiting. Review of the resident's fecal occult blood immunochem (a test that screens for colon cancer by using antibodies to detect blood in the stool) lab result, showed: -Collection date of [DATE] (20 days after the STAT order was obtained); -Reported date of [DATE]; -Result: negative. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on [DATE] at 4:28 PM the Director of Nursing said the facility had to go through the hospital to get the laboratory testing completed for Resident #144. The resident expired before the results came back. The facility had been told that the laboratory was supposed to have a four hour result time for STAT results. Since the hospital drew the blood work, the hospital will only call the facility if the results are at a critical level. Since the resident's results were not critical, the hospital did not report the results to the facility and sent the results back to the laboratory and then the results were faxed over to the facility from the laboratory. By the time the blood work results came through, the resident had expired. The nurses should have been calling the hospital and the laboratory for the STAT results. The staff should have also been documenting attempts to contact the hospital and laboratory. The nursing management had done an in-service with the staff nurses regarding communication and follow up for ordered labs. 37672

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36151 Based on observation and interview, the facility failed to serve and store food under sanitary conditions by not dating and covering stored food, thawing frozen food properly, ensuring food was covered during meal service and that staff serving food did not touch food contact surfaces. In addition, two ice machines used for residents had no air-gap. These deficient practices had the potential to affect all residents who ate at the facility. The census was 146. 1. Observation of the kitchen on 12/17/19 at 8:52 A.M., showed: -On the prep table, a small container of sugar. Inside the container, a measuring spoon; -An opened box of baking soda, not covered; -Inside the walk in cooler: -Approximately 22 individual sized mixed fruit containers, not dated; -An opened bag of buns, not dated; -An opened bag of carrots, not dated; -An opened bag of croutons, not dated; -A large container of cranberry sauce, opened, not dated; -A tub of opened salad dressing, not dated; -Inside a metal tub, approximately five containers of salad dressings, opened to air and not dated; -Inside the walk in freezer, opened packages of frozen pies, not dated. 2. Observation of the kitchen on 12/17/19 at 12:33 P.M., showed five large blocks of hamburger thawed inside a large sink as water ran into the sink. A white wash rag plugged the drain and water filled the sink. At 12:35 P.M., an unidentified dietary staff person walked past the sink and shut off the water. At 1:06 P.M., the hamburger sat in the sink, thawing, the water not running. 3. Observation of the kitchen on 12/17/19 at 12:35 P.M., showed the ice machine drained directly into the drain, with no air-gap observed to protect ice from possible contamination. 4. Observations of the 100 Hall, main dining room, showed: -On 12/17/19: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 12:40 P.M., six plates of open faced hamburgers, sat on top of a three tiered serving cart, uncovered, as dietary staff wheeled the cart through the dining room, in between the seated residents; -At 12:44 P.M., five plates of open faced hamburgers, sat on top of a three tiered serving cart, uncovered, as dietary staff wheeled the cart through the dining room, in between the seated residents; -At 12:55 P.M., dietary staff wheeled a multi-level cart, filled with sliced red velvet cake, uncovered, through the dining room, as staff asked residents if they would like a slice of cake; -On 12/18/19: -At 8:20 A.M., dietary staff wheeled a three tiered cart through the dining room, in between residents as they waited for their breakfast. On the top of the cart were four plates of eggs, sausage patties and toast, and two bowls of hot cereal, uncovered; -At 8:25 A.M., dietary staff wheeled a three tiered cart through the dining room, in between residents as they waited for their breakfast. On the top of the cart, were two plates, both with peeled boiled eggs and toast, uncovered; -At 12:42 P.M., dietary staff wheeled a three tiered cart through the dining room, in between residents as they sat at their tables. On the cart were 12 plates of country fried steak or ham, mashed potatoes and bread, uncovered, as staff asked which they would prefer; -At 12:44 P.M., dietary staff wheeled a three tiered cart through the dining room, in between residents as they sat at their tables. On the cart were six plates of country fried steak or ham, mashed potatoes and bread, uncovered, as staff asked which they would prefer; -At 12:51 P.M., two additional carts wheeled past residents, with twelve plates of country fried steak or ham, mashed potatoes and bread, uncovered, as staff asked which they would prefer. 5. Observation of the 100 Hall meal service on 12/18/19 at 8:32 A.M., showed a serving cart sat on the hallway as staff plated food for individual resident hall trays. All of the individual food items, eggs, sausage, hot cereal, and two cups of poured coffee sat uncovered as dietary staff plated food and additional staff and residents walked behind the cart with no hair nets on. No protective barrier observed on the cart between the residents/staff and food. 6. Observation on 12/19/19 at 6:00 P.M., showed Certified Nursing Assistant (CNA) DD went to the steam table to pick up a plate and deliver the plate to a resident. CNA DD held the plate with four fingers under the plate and his/her thumb inside the plate. CNA DD returned to the steam cart to collect another plate and served the plate in the same manner, until all the residents in the dining room were served. CNA DD did not wear gloves or sanitize his/her hands between plate service. 7. Observation of the 100 Hall kitchenette on 12/20/19 at 4:30 P.M., showed the ice machine drained into a funnel, between the drain and the ice machine drain. The funnel rose above the ice machine drain. No air gap was observed to protect the ice from possible contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. During an interview on 12/20/19 at 5:03 P.M., the Dietary Manager said food should not be thawed under standing water, the water should be running. All items stored in the freezer/refrigerators should be dated and covered. During meal service, food should be covered and staff should sanitize their hands before handling food. She said the ice machines should have an air gap and the facility does not have a policy on food storage. 42247

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 Based on interview and record review, the facility failed to implement an effective quality assurance (QA)/quality assurance performance improvement (QAPI) program when they did not implement appropriate interventions to correct on-going, systemic issues. In addition, the facility's QA/QAPI committee failed to identify a widespread deficiency that caused immediate jeopardy to resident health or safety. This deficient practice had the potential to affect all residents. The sample was 29. The census was 149. Review of the facility's Quality Assurance Process Improvement and Compliance (QAPIC) policy, last revised on [DATE], showed: -This organization is committed to providing quality services in a safe, ethical and competent fashion. The purpose of this plan is to provide a framework using common principles found in risk management, quality improvement and compliance methodologies for the development of structures and processes that support the mission and values of our organization; that encourage a systems approach to performance assessment and improvement; that promotes high quality resident care; that protects facility assets; and that fosters a culture of compliance with all regulatory and ethical standards; -QAPIC efforts will be ongoing, comprehensive and will encompass the full range of services performed by the facility and its departments including but not limited to clinical care, quality of life, resident rights, safety, operations, billing, human resources and management practices. 1. Review of the Centers for Medicare and Medicaid services (CMS) form 2567, dated [DATE], showed the following deficiencies identified: -F678: The facility failed to obtain a signed code status sheet or failed to obtain physician orders for code status for four of 29 sampled residents; -F623: The facility failed to issue written transfer notices to residents and/or their representative upon discharge to a hospital when their return to the facility was expected; -F625: The facility failed to inform the resident and family or legal representative of their bed hold policy at the time of transfer to the hospital; -F641: The facility failed to ensure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment; -F656: The facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents; -F679: The facility failed to implement an ongoing resident centered activity program that incorporates the resident's interests to maintain and/or improve a resident's physical, mental and psychosocial well-being; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-F690: The facility failed to maintain proper insertion of an indwelling urinary catheter (a tube inserted into the bladder for the purpose of continual urine drainage); -F698: The facility failed to provide thorough assessments, on-going monitoring and communication with the dialysis center; -F759: The facility failed to ensure a medication error rate of less than 5%; -F812: The facility failed to date all health shakes and failed to ensure the dish machine sanitized properly. Review of the CMS form 2567, dated [DATE], showed the following deficiencies identified: -F678: The facility failed to obtain an ordered code status for 13 residents, failed to essure residents/resident representatives wishes for code status matched the physician ordered code status, failed to ensure one resident's code status was ordered timely after admission and failed to ensure a process for staff to know a resident's code status in the event of electrical or electronic medical record outage; -F623: The facility failed to issue written transfer notices to residents and/or their representative upon transfer to a hospital when their return to the facility was expected; -F625: The facility failed to inform the resident and family and/or legal representative of their bed hold policy at the time of transfer to the hospital; -F641: The facility failed to ensure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment; -F656: The facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents; -F679: The facility failed to provide, based on the comprehensive assessment, care plan and preferences of each resident, an ongoing program to support residents in their choice of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident; -F690: The facility failed to maintain proper placement of a urinary catheter and position of the catheter tubing; -F698: The facility failed to provide thorough assessments, on-going monitoring and communication with the dialysis center; -F759: The facility failed to ensure a medication error rate of less than 5%; -F812: The facility failed to serve and store food under sanitary conditions by not dating and covering stored food, thawing frozen food properly, ensuring food was covered during meal service and that staff serving the food did not touch food contact surfaces. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on multiple deficiencies cited in resident rights; admission, transfer and discharge; resident assessments; comprehensive resident centered care plan; quality of life; quality of care; pharmacy services; and food and nutrition services, the facility failed have an effective quality assessment and assurance program to ensure staff identify issues and develop and implement appropriate plans of action to correct identified deficiencies that affect the residents' health, safety and quality of life. During an interview on [DATE] at 5:41 P.M., the administrator said the Quality Assurance and Performance Improvement team meets at least quarterly to identify and correct deficient practices. 2. Based on observation, interview and record review, the facility failed to ensure staff were able to provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care in accordance with physician's orders and the resident's advance directives by failing to have a system in place to ensure resident's code status was documented and staff were able to quickly identify a resident's code status when needed. The facility failed to obtain an ordered code status for 13 residents, failed to ensure residents/resident representatives wishes for code status matched the physician ordered code status for two residents, failed to ensure one resident's code status was ordered timely after admission and failed to ensure a process for staff to know a resident's code status in the event of electrical or electronic medical record outage. During an interview on [DATE] at 5:41 P.M., the administrator said the Quality Assurance and Performance Improvement team had not identified code status as an issue. The facility had switched over from paper charting to the electronic records and they had not identified the location of resident code statuses as an issue. 36151

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	12/24/2019

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37672 Based on interview and record review, the facility failed to follow their policy on employee tuberculosis (TB) testing for seven of 10 sampled employees. The census was 146. Review of the facility's TB screening for long term care employees policy, updated 3/11/14, showed: -If no documentation of a prior two step tuberculin skin test (TST): Administer the first step TST prior to employment, can coincide reading the results with employment start date by administering the TST 2-3 days prior to employee start date; -If there is documentation of a first step TST with negative results within the past year: Administer the second step within 1-3 weeks; -If documentation of a two-step TST in the past and at least one subsequent annual test within the past year, all negative: Do a first step TST by anniversary date of the last TST and then annually; -Read results within 48-72 hours of administration. 1. Review of the employee file for Laundry Aide KK, showed: -Date of Hire (DOH) 6/19/19; -First step TST administered 6/17/19 and read negative on 6/19/19; -No second step TST administered or read. 2. Review of the employee file for Certified Nursing Assistant LL, showed: -DOH 11/13/19; -First step TST administered 11/12/19 and read negative on 11/14/19; -No second step TST administered or read. 3. Review of the employee file for Licensed Practical Nurse MM, showed: -DOH 1/16/19; -No documentation of first or second step TST administered or read. 4. Review of the employee file for Social Worker NN, showed: -DOH 4/24/19; -First step TST administered on 4/22/19 and read negative on 4/24/19; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No second step TST administered or read. 5. Review of the employee file for Dietary Aide OO, showed: -DOH 9/18/19; -No documentation of first or second step TST administered or read. 6. Review of the employee file for Receptionist PP, showed: -DOH 10/30/19; -No documentation of first or second step TST administered or read. 7. Review of the employee file for Cook QQ, showed: -DOH 10/30/19; -No documentation of first or second step TST administered or read. 8. During an interview on 12/20/19 at 4:41 P.M., the Director of Nursing said the staff development coordinator usually does the new hire PPD's. She would have expected the facility policy to be followed. For several months, the facility did not have a staff development coordinator and several new hires may have been missed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32847 36151 Based on observation, interview and record review, the facility failed to ensure a pressure reducing air mattress (a mattresses which redistributes a patient's weight so as to relieve pressure points) was maintained in a safe operating condition, for one resident (Resident #118) of 29 sampled residents. The census was 146. 1. Review of Resident #118's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Two staff person assist for activities of daily living; -Upper/lower extremity impairment of both sides; -Wheelchair for mobility; -One Stage III pressure ulcer (full thickness tissue loss injury to the skin as a result of pressure or friction, subcutaneous fat may be visible but the bone, tendon or muscle is not exposed); -One unstageable pressure ulcer (depth of the wound is unable to be determined); -Diagnoses included quadriplegia (paralysis of all four limbs), multiple sclerosis, (MS, disease in which the immune system eats away at the protective covering of nerves), heart failure, high blood pressure, kidney failure, and diabetes. Review of the resident's care plan, in use during the survey, showed: Problem: Resident has a history of having a healed wound. He/she is at risk for developing other pressure related areas due to refusing to offload the area, incontinent of bowel and requiring assistance with turning and repositioning while in bed. He/she refuses to return to bed once he/she gets up into the motorized wheelchair and stays up for prolonged period of times; -The resident's skin will remain intact through review date. Inform him/her/family/caregivers and physician of any new area of skin breakdown. Instruct/assist him/her with shifting his/her weight in wheelchair on a frequent basis. Needs monitoring/reminding/assistance, to turn/reposition at least every 2 hours, more often as needed or requested. Review of the resident's electronic physician order sheet, showed an order dated 6/14/17, for a low air loss mattress for pressure prevention. During an interview on 12/18/19 at 11:45 A.M., the nurse practitioner said the resident was hospitalized on [DATE] and returned with a worsened wound from the hospital. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/19/19 at 7:57 A.M., slowed Licensed Practical Nurse (LPN) N and Certified Nursing Assistant (CNA) K provided care for the resident. The resident lay on his/her right side. The resident's air mattress alarmed, turned off and then immediately kicked back on. The resident said this happens, there is a short. Staff have to come back in to fix it when it turns off. CNA K said he/she will tell maintenance. Observation of the front control panel of the air mattress, showed three buttons cracked through the plastic cover and exposed the inner workings of the machine. Staff assisted the resident to the left side. The air mattress turned off again. The resident said LPN N must have hit the cord, so the air mattress turned off. The resident's air mattress had gone flat. LPN N adjusted the electrical cord and the air mattress turned back on. The resident said the bed does this at times, ever since he/she got it. CNA K said the dysfunction of the air mattress might happen at night and no one would know. During an interview on 12/20/19 at 4:02 P.M., the resident said if you bump the bed, it will deflate. The bed had stayed deflated as long as thirty minutes at a time, it is very uncomfortable when the bed deflated. During an interview on 12/20/19 at 4:07 P.M., LPN UU said he/she was aware the bed deflates when the plug is bumped. During an interview on 12/20/19 at 3:11 P.M., the Maintenance Director said any staff person can report an environment concern to maintenance. Maintenance staff complete room audit check sheets periodically. The sheets were part of the Quality Assurance and Performance Improvement (QAPI) plan. He would expect staff to report issues with an air mattress. Maintenance was not aware of the issue. No staff had reported this issue as of this time.