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	01/25/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation and interview, the facility failed to maintain resident dignity by failing to sit while assisting two (Residents #93 and #115) of 28 sampled residents with meals. The census was 121. Review of the facility's Resident's Right policy, revised 8/2021, showed: -Policy Statement: Employees shall treat all residents with kindness, respect and dignity; -Policy Interpretation and Implementation: -Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: -A dignified existence; -Be treated with respect, kindness and dignity. 1. Review of Resident #93's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/13/21, showed: -admitted on [DATE]; -Exhibited moderate cognitive impairment; -No behaviors; -Required supervision and set up from staff for eating. Review of the resident's care plan, updated on 12/13/21, in use during the survey, showed: -Focus: The resident has an activities of daily living deficit related to activity intolerance and impaired balance; (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal: The resident will maintain current level of function in activities of daily living through the review date; -Interventions: The resident is able to feed him/herself with set-up help. Observation on 1/19/22 at 12:59 P.M., showed the resident sat up in bed. Certified Medication Technician (CMT) K stood beside the resident's bed and fed him/her lunch. Observation on 1/20/22 at 12:53 P.M., showed the resident sat in bed. CMT K stood beside the resident's bed and fed him/her lunch. 2. Review of Resident #115's quarterly MDS dated [DATE] and reviewed on 1/25/22 at 7:34 A.M. showed: - Diagnoses included dementia, hemiplegia (the functional use of the upper limbs only), seizure disorder, anxiety, depression, and psychotic disorder. -BIMS score of 9 showing moderate cognitive impairment. Review of the resident's care plan, in use during the survey, showed: -Resident prefers to eat his meals in bed; -Resident is on a pureed diet; -Resident required full assistance with all meals; -Resident will drink supplements if offered; -Recommendation for the resident to receive supercereal with breakfast. Observation of the lunch meal on 1/20/22 at 12:56 P.M. showed Certified Nursing Assistant (CNA) A assisting the resident in eating his/her tray of food. CNA A stood next to the resident's bed while feeding the resident. An empty chair was visualized near the head of the resident's bed. Observation of the breakfast meal on 1/24/22 at 8:43 A.M., showed CNA A standing to feed the resident while he/she lay in bed. An empty chair was visualized at the head of the resident's bed. 3. During an interview on 1/25/22 at 8:50 A.M., Nurse M said it was the staff's preference to either sit or stand while feeding residents. Eye contact was important when feeding residents. 4. During an interview on 1/25/22 at 8:55 A.M., CNA L said it was best to feed residents while standing. This was how he/she fed his/her children. 5. During an interview on 1/25/22 at 11:51 A.M., the administrator and Director of Nursing (DON) said staff should sit while feeding residents to maintain their dignity. It was not appropriate to stand while feeding residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44948

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 37681 Based on observation and interview, the facility failed to provide reasonable accomodations of resident needs and preferences by not serving meals in a timely manner and at the posted times. This deficient practice affected all residents who ate at the facility. The census was 121. During an interview on 1/18/22 at 8:30 A.M., the Dietary Manager said breakfast was served at 8:00 A.M., lunch was served at 12:00 P.M. and dinner was served at 5:00 P.M. There were three cooks and six dietary aides (DA) working in the kitchen. The main dining room was in use and some residents received meals delivered to their room. Observations of the lunch meal service in the main dining room on 1/18/22, showed: -At 12:02 P.M., eight residents sat in the dining room; -At 12:16 P.M., approximately 10 residents sat in the dining room. No drinks or food were served; -At 12:36 P.M., a DA passed hand sanitizer to residents; -At 12:45 P.M., the DA brought juice and coffee to the main dining room and began to serve drinks to the residents; -At 12:46 P.M., the first plate of food was served in the dining room. During a group interview on 1/20/22 at 2:00 P.M., four out of six residents said meal times in the facility vary from day to day. Breakfast might be served at a certain time one day, then an hour later the next day. Some residents sit in the dining room for hours waiting for dinner to arrive. Residents prefer meals to be served at consistent times each day. Observation of the lunch meal service on 1/24/22, showed: -At 11:28 A.M., one cook and three dietary aides were present in the kitchen. The cook prepared food, one DA filled pitchers with ice, another DA stuffed plastic silverware into bags and the third dietary DA was in the dishwash area cleaning the floor; -At 11:37 A.M., DA E grabbed three rolling unheated carts, where the food would be stored, to deliver to the residents' unit. He/she placed cookies, coffee and plastic silverware on the carts; -At 11:48 A.M., the cook placed the prepared food in the food warmers for serving; -At 11:53 A.M., the food sat in the server. Divided Styrofoam plates sat next to the food. DA E placed beverages on the carts for delivery to the units, DA D stuffed plastic silverware in the bags, the cook cleaned his/her dishes and another DA was in the dishwashing area wiping down surfaces; -At 12:02 P.M., DA E delivered coffee and juice to the main dining room; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:11 P.M., DA D said he/she would start with the main dining room, and began plating food; -At 12:18 P.M., DA E took the first six plates of food out to the main dining room; -At 12:27 P.M., DA E took the remaining plates of food out to the main dining room; -At 12:28 P.M., DA D began plating food for the first floor, using the divided Styrofoam trays; -At 12:32 P.M., DA E placed the trays of food on a cart and delivered them to the first floor; -At 12:35 P.M., DA D began plating food for the second floor main unit; -At 12:52 P.M., DA E placed the trays of food on the cart and delivered them to the second floor main unit; -At 12:54 P.M., DA D began plating food for the second floor south unit; -At 12:59 P.M., DA E placed the trays of food on the cart and delivered them to the second floor south unit. DA D began plating food for the third floor; -At 1:05 P.M., DA D told the cook he/she needed more rice or potatoes and stopped plating the food; -At 1:11 P.M., DA D resumed plating after receiving a pan of potatoes; -At 1:16 P.M., DA D told the cook he/she needed more vegetables and stopped plating; -At 1:21 P.M., the vegetables were delivered and DA D resumed plating; -At 1:23 P.M., DA E placed the trays of food on the cart and delivered them to the third floor main unit. During an interview on 1/25/22 at 7:14 A.M., the Dietary Manager said she was aware of residents complaining of meals being late. The dietary staff were in-serviced on serving meals in a timely manner. They were supposed to plate earlier than noon to ensure meals were delivered on time. During an interview on 1/25/22 at 1:51 P.M., the administrator and Director of Nursing (DON) said food should be served on time at the stated times.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 29948 Based on interview and record review, the facility failed to ensure the rights of one resident (Resident #55) out of 24 sampled residents, for unrestricted visitation, when the facility prevented the resident's care and financial power-of-attorney (POA, a person with the legal authority to make decisions regarding another person's medical care and financial matters) from entering the facility, contacting the resident by phone and did not set up visits via a virtual video teleconferencing platform. The census was 121. Review of the facility's policy titled, Resident's Rights, effective 9/2015, showed federal and state laws guaranteed certain basic rights to all residents of the facility. Those rights included the right to visit and be visited by others from outside the facility, access to a telephone, communication with and access to people and services, both inside and outside of the facility and to be supported by the facility in exercising his/her rights. Review of the resident's undated face sheet, showed he/she had a care and financial POA. The face sheet showed special instructions for staff that the POA was not allowed in the facility at all. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/3/21, showed the following: -Severe cognitive impairment; -Verbal behavioral symptoms directed at others occurred 1-3 days; -Wandering occurred four to six days, but less than daily; -Wheelchair mobility; -Diagnoses including dementia, manic depression and repeated falls. Review of the resident's undated care plan,showed the following: -The resident is not cognitively stable and is not capable of using a call light for assistance; -Poor safety awareness and decreased comprehension; -Activities of daily living (ADL) self-care performance deficit related to confusion and dementia; -The resident has a diagnosis of dementia, has a history of resistance to care, as well as a history of agitated, delusional, hyperactive behaviors. Further review of the resident's care plan, did not show any documented reason for or exceptions to the special instructions for staff not to allow the POA inside the facility. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's undated clinical physician orders, showed undated special instructions showing the resident's POA was not allowed in the facility at all. During an interview on 1/21/22 at 11:08 A.M., the social services director said she was unaware of any special instructions directing staff not to allow the POA in the facility. He/she had not set up any virtual visits between the resident and POA. During an interview on 1/28/22 at 2:56 P.M., the Director of Nursing said it was her understanding that the restriction of the POA not being allowed in the facility was confined to the day that staff asked the POA to leave, due to unsafe behavior. During an interview on 1/27/22 at 12:07 P.M., the Medical Director/primary care physician said the special instructions on the resident's physician's orders directing staff not to allow the resident's POA to visit was not an order issued by him. Facilities never contacted physicians for issues of that nature. During an interview on 1/25/22 at 8:54 A.M., the POA said on the day of the incident, he/she had put a small . 38 caliber gun in the left pocket of his/her jeans, while moving and forgot about it. In the lobby of the facility, the POA reached into a back pocket and the receptionist saw the gun in the front pocket. The POA never took it out of his/her pocket. The receptionist saw the outline of it and asked, Is that a gun in your pocket? The POA said yes, and the receptionist told the POA to leave. He/she was not given the option of returning without the gun. The social worker called and said the POA was not allowed to return to the facility. Staff also did not allow him/her to speak to the resident on the phone. The POA had not spoken to the resident since July 2021. No one attempted to set up virtual visits. Staff refused to bring the resident downstairs, so that the POA could stand at a window and see the resident, in order to make sure the resident was alright and still wearing both his/her glasses and hearing aids. During an interview on 1/28/21 at 2:19 P.M., the administrator said she was unaware of the special instructions on the resident's face sheet and physician's orders directing staff not to allow the POA in the facility. Those special instructions were never a physician's order. The administrator said there was an incident in which the POA came up to the facility for a visit with the resident, a gun fell out of his/her pocket and he/she pushed it back in. During the interview, the administrator reviewed social service notes and found an entry from the former social worker dated 11/5/21, documenting a call to the POA to discuss the incident and the social worker telling the POA that the POA was not allowed to enter the building, due to the threatening behavior. The administrator said she did not understand why the special instruction that the POA was not to enter the facility was placed on the resident's face sheet and physician's orders for an isolated incident. Other than the incident with the gun, she had no problem with the POA. During the interview, the administrator removed the special instructions from the face sheet and physician's orders. The administrator was not aware of any attempt made by staff to set up virtual visits between the POA and resident. MO00194059

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 40290 Based on interview, the facility failed to ensure the Business Office Manager (BOM) had access to all resident funds, and to ensure resident requests for less than $100.00 ($50.00 for Medicaid residents) are honored within the same day by not assuring residents had access to their trust account on the weekends. This deficient practice affected all the residents who had a resident trust account. The census was 121. During an interview on 1/25/22 at 10:52 A.M., the BOM said she became employed with the facility in November, 2021. Resident funds are held in the resident trust fund account. In October 2021, the facility changed ownership and opened a new resident trust fund account, Account B. The BOM did not have access to the old account, Account A, until late in December 2021. Funds were held in both accounts until Account A was closed last week. Withdrawals for resident funds are made from a separate account, Account C, through a different bank. BOM does not have access to the account, other than to make withdrawals. She does not know where the money in Account C comes from, or how it is replenished. When residents make requests for less than $100.00, she issues a check and withdraws the money from Account C. If a resident requests money, they usually get it on the same day or at least the next day, depending on when they make the request. If a resident requests money on Friday, the residents know they are not going to get their money on the weekend. The facility has not given residents money on the weekends in the past two months. During an interview on 1/25/22 at 3:28 P.M., the BOM and administrator said residents should have access to money on the weekends. The administrator said there is a box of money at the front desk for residents who request money on the weekends. The BOM should be aware of all resident funds available. She should have had access to Account A, which was still in use when the facility opened Account B.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 40290 Based on interview and record review, the facility failed to ensure general accounting principles were followed by failing to provide explanations for discrepancies noted during monthly resident trust fund reconciliations for two accounts, and by failing to complete monthly account reconciliations for a third account in which resident funds were held. In addition, the facility failed to follow up on outstanding checks, and failed to provide quarterly statements to residents and their representatives. This affected 110 residents whose funds were handled by the facility. The census was 121. Review of the facility's Cash Disbursement Procedure policy, undated, showed no guidance regarding resident trust account reconciliation, outstanding checks, or quarterly statements. 1. Review of the facility's Trust Account Reconciliation from January through December 2021, showed: -January 2021: -Bank balance as of 1/31/21: $157,485.53; -Total of 111 resident accounts as of 1/31/21: $157,723.77; -The facility showed a difference of $0.00; -Discrepancy explanation: blank; -February 2021: -Bank balance as of 2/28/21: $156,399.65; -Total of 109 resident accounts as of 2/28/21: $156,393.66; -The facility showed a difference of $0.00; -Discrepancy explanation: blank; -March 2021: -Bank balance as of 3/31/21: $148,623.83; -Total of 110 resident accounts as of 3/31/21: $148,617.45; -The facility showed a difference of $0.00; -Discrepancy explanation: blank; (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-April 2021: -Bank balance as of 4/30/21: $237,657.51; -Total of 111 resident accounts as of 4/30/21: $237,648.28; -The facility showed a difference of $0.00; -Discrepancy explanation: blank; -May 2021: -Bank balance as of 5/31/21: $229,066.66; -Total of 110 resident accounts as of 5/31/21: $229,056.77; -The facility showed a difference of $0.00; -Discrepancy explanation: blank; -June 2021: -Bank balance as of 6/30/21: $218,730.98; -Total of 110 resident accounts as of 6/30/21: $218,960.59; -The facility showed a difference of -$238.85; -Discrepancy explanation: blank; -July 2021: -Bank balance as of 7/31/21: $183,994.58; -Total of 108 resident accounts as of 7/31/21: $184,465.10; -The facility showed a difference of -$479.25; -Discrepancy explanation: blank; -August 2021: -Bank balance as of 8/31/21: $181,660.75; -Total of 107 resident accounts as of 8/31/21: $181,652.90; -The facility showed a difference of $0.00; (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Discrepancy explanation: blank. -September 2021: -Bank balance as of 9/30/21: $180,421.71; -Total of 110 resident accounts as of 9/30/21: $180,414.19; -The facility showed a difference of $0.00; -Discrepancy explanation: blank. -October 2021: -Bank balance as of 10/31/21: $173,758.64; -Total of 112 resident accounts as of 10/31/21: $173,996.02; -The facility showed a difference of $0.00; -Discrepancy explanation: blank. -November 2021, Account A: -Bank balance as of 11/30/21: $162,051.33; -Total of 110 resident accounts as of 11/30/21: $162,293.83; -The facility showed a difference of $7.10; -Discrepancy explanation: blank. -November 2021, Account B: -Bank balance as of 11/30/21: $27,679.62; -Total of 110 resident accounts as of 11/30/21: $27,679.04; -The facility showed a difference of $0.00; -Discrepancy explanation: blank. -December 2021, Account A: -Bank balance as of 12/31/21: $157,911.22; -Total of 105 resident accounts as of 12/31/21: $158,143.80 (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The facility showed a difference of $4.92; -Discrepancy explanation: blank. -December 2021, Account B: -Bank balance as of 12/31/21: $29,840.04; -Total of 110 resident accounts as of 12/31/21: $29,839.06; -The facility showed a difference of $0.00; -Discrepancy explanation: blank. During an interview on 1/25/22 at 10:52 A.M., the Business Office Manager (BOM) said she has been in her current position with the facility since November 2021. Resident funds are held in the resident trust fund account. Prior to October 2021, all resident funds were held in Account A. In October 2021, the facility changed ownership and a new resident trust fund account, Account B, was opened. In November and December 2021, the facility held resident funds in two separate accounts, Account A and Account B. The BOM reconciled both Account A and Account B in November and December 2021. Account B was closed last week. The facility should have been using one account for resident funds because two separate accounts will not ensure accurate balances. The resident trust fund, including petty cash, should be reconciled with the bank statements each month. Every month, there should be a $0 balance after the reconciliation is done and the amounts should balance out. She thinks the reconciliation between each month does not match due to checks that had not cleared. 2. During an interview on 1/25/22 at 10:52 A.M., the BOM said when a resident requests a small amount of cash, such as $5.00, the facility can give the resident money from the box. Social Services (SS) gives the BOM the resident's request for money and the money is taken from the box and given to SS to give to the resident. The resident signs off on receiving the money. There is no set amount of money maintained in the box and she does not know where the money in the box came from, but money in the box is considered resident funds. The BOM counted the money contained in the box, which totaled $186.00. She did not reconcile the box money in November or December 2021. When residents request additional funds, the BOM issues a check and withdraws the money from Account C, which is through a different bank than the resident trust accounts. The only access she has to Account C is for withdrawals. She does not know where the money in Account C comes from or how it is replenished. Since Account C is used for resident funds, it should be reconciled monthly. Review of the facility's resident trust account documentation, showed no bank statements, trial balance reports, or trust account reconciliation regarding Account C. 3. Review of the facility's Disbursement Checking Account Reconciliation, effective 11/30/21, showed: -Check, dated 3/5/15, for $50.00; -Check, dated 4/16/15, for $50.00; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Check, dated 7/21/15, for $11.86; -Check, dated 9/28/16, for $0.89; -Check, dated 10/4/16, for $30.00; -Check, dated 11/21/16, for $0.04; -Check, dated 1/26/17, for $773.80; -Check, dated 9/6/17, for $1,214.90; -Check, dated 11/8/17, for $8.43; -Check, dated 7/13/18, for $50.00; -Check, dated 9/14/18, for $50.00; -Check, dated 11/7/18, for $835.76; -Check, dated 11/9/18, for $30.00; -Check, dated 12/17/18, for $13.00; -Check, dated 2/14/19, for $50.00; -Check, dated 10/23/19, for $426.71; -Check, dated 12/12/19, for $989.00; -Check, dated 1/27/20, for $30.28; -Check, dated 3/1/21, for $1,760.49; -Check, dated 4/2/21, for $41.00; -Check, dated 6/14/21, for $50.00; -Check, dated 7/15/21, for $696.24; -Check, dated 11/16/21, for $2,249.16; -Check, dated 11/18/21, for $569.94; -A total of $9,981.50 in outstanding checks. Review of the facility's Disbursement Checking Account Reconciliation, effective 12/31/21, showed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Check, dated 3/5/15, for $50.00; -Check, dated 4/16/15, for $50.00; -Check, dated 7/21/15, for $11.86; -Check, dated 9/28/16, for $0.89; -Check, dated 10/4/16, for $30.00; -Check, dated 11/21/16, for $0.04; -Check, dated 1/26/17, for $773.80; -Check, dated 9/6/17, for $1,214.90; -Check, dated 11/8/17, for $8.43; -Check, dated 7/13/18, for $50.00; -Check, dated 9/14/18, for $50.00; -Check, dated 11/7/18, for $835.76; -Check, dated 11/9/18, for $30.00; -Check, dated 12/17/18, for $13.00; -Check, dated 2/14/19, for $50.00; -Check, dated 10/23/19, for $426.71; -Check, dated 12/12/19, for $989.00; -Check, dated 1/27/20, for $30.28; -Check, dated 3/1/21, for $1,760.49; -Check, dated 4/2/21, for $41.00; -Check, dated 6/14/21, for $50.00; -Check, dated 7/15/21, for $696.24; -Check, dated 11/16/21, for $2,249.16; -Check, dated 11/18/21, for $569.94; (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Check, dated 12/21/21, for $3,336.00; -Check, dated 12/21/21, for $1,940.00; -Check, dated 12/30/21, for $90.90; -Check, dated 12/30/21, for $50.80; -Check, dated 12/30/21 for $181.81; -A total of $15,581.11 in outstanding checks. During an interview on 1/25/22 at 10:25 A.M., the BOM said old outstanding checks should be voided. As of right now, there is resident money floating around that is not accounted for. The BOM should follow up on old checks issued to account for resident money. 4. Review of resident trust fund documentation from 1/2021 through 12/2021, showed no quarterly statements provided to residents from 1/1/21 through 9/30/21. During an interview on 1/25/22 at 10:52 A.M., the BOM said residents and their representatives should receive quarterly statements showing the resident's current balance and list of transactions during the previous three months. She was unable to locate documentation to show quarterly statements were provided from 1/1/21 through 9/30/21. On 1/24/22, she received the quarterly statements for October through December 2021, which had not yet been provided to residents and their representatives. 5. During an interview on 1/25/22 at 3:28 P.M., the administrator said the facility did not have any polices regarding funds, other than the Cash Disbursement Procedure policy. She would expect all resident money to be accounted for. The facility should follow up on outstanding checks. When reconciling the resident trust account, there should be a $0 difference. Accounts holding resident money should be reconciled monthly, including Account C. She would expect residents and their responsible parties to receive quarterly statements.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed for the final accounting for residents who expired, within 30 days. This affected five residents who expired and had money in their account (Residents #323, #322, #350, #321 and #320). The census was 121. 1. Review of Resident #323's resident fund account, showed the following: -He/she expired on [DATE]; -He/she had a balance of $866.38; -No documentation of TPL completed. 2. Review of Resident #322's resident fund account, showed the following: -He/she expired on [DATE]; -He/she had a balance of $2,441.22; -No documentation of TPL completed. 3. Review of Resident #350's resident fund account, showed the following: -His/her account closed on [DATE]; -He/she had a balance of $90.00; -No documentation of TPL completed. 4. Review of Resident #321's resident fund account, showed the following: -He/she expired on [DATE]; -He/she had a balance of $5,499.72; -No documentation of TPL completed. 5. Review of Resident #320's resident fund account, showed the following: -He/she expired on [DATE]; -He/she had a balance of $90.90; (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No documentation of TPL completed. 6. During an interview on [DATE] at 2:41 P.M., the Business Office Manager (BOM) said Resident #350 was found unresponsive and was sent to the hospital on [DATE], where he/she expired. His/her account was closed on [DATE] and the facility issued a check for his/her funds to the resident. Resident #320 expired on [DATE] and the facility issued a check for his/her funds to go to the resident. Checks for expired residents should not be issued to the resident who expired. When a resident has funds held by the facility and the resident expires, the BOM should fill out a TPL form and submit it to the State of Missouri, Department of Social Services (DSS), within 30 days. DSS determines where the resident's remaining funds should be distributed. The BOM could not locate TPL forms or receipts for funeral expenses for the expired residents sampled. 7. During an interview on [DATE] at 3:28 P.M., the administrator said when a resident has funds held by the facility and the resident has a balance when they expire or transfer, she expected the State of Missouri to be notified of funds remaining in the resident's account.

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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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 40290 Based on interview and record review, the facility failed to ensure they maintained an adequate surety bond for the resident trust fund account in the amount of one and one half times the average monthly balance for the past 12 months. The census was 121. Review of the facility's Cash Disbursement policy, undated, showed no instructions on how to monitor the facility's surety bond to ensure it was sufficient. Review of the resident trust account for the past 12 months, from January 2021 to December 2021, showed an average monthly balance of $187,000. (This would yield a required bond in the amount of $280,500 (one and one half times the average monthly balance)). Review of the bond report for approved facility bonds by Department of Health and Senior Services (DHSS), showed an approved bond of $270,000, dated 12/17/21. Review of the ending balance for December 2021, showed an amount of $187,982.86. During an interview on 1/25/22 at 3:28 P.M., the business office manager (BOM) and administrator said the facility does not have any additional policies regarding funds. The corporate office oversees the bond amount to make sure it is sufficient.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 29948 44948 Based on observation, interview and record review, the facility failed to ensure residents' responsible parties were notified in the event of a significant change for 1 of 24 sampled residents (Resident #55). The census was 121. Review of the facility's Notification of Change policy, revised November 2017, showed the following: -In an emergency situation, the physician is contacted at the same time or will be notified following 911 and once the resident is transferred to the hospital; -In a non-emergent, but acute medical situation (including critical lab values and other diagnostic results) the physician will be paged and if there is no return call in 15 minutes the physician will be notified again. If there is no return call in 5 minutes the Medical Director will be notified; -In a non-emergent, non-acute medical situation, such as normal labs, the physician can be contacted at their convenience; -Any questions about how to notify the physician should be directed to the Director of Nurses (DON), Assistant Director of Nurses (ADON), or nursing supervisor. Review of Resident #55's progress note, dated 6/18/21, showed the following: -Resident was found in the fetal position on the bed moaning in pain; -Blood-tinged stool could be seen on the floor of the resident's room; -On call MD was contacted and gave orders to send resident out to the hospital for evaluation; -Emergency medical services (EMS) arrived around 9 P.M. that evening; -Staff did not document contacting the resident's responsible party. Further review of the resident's progress note, dated 11/4/21 at 9:41 P.M., showed the following: -Resident was found sitting on the floor in his/her room stating he/she had slipped and fallen. -Resident was assisted up off of the floor and onto his/her bed; -Vital signs were taken and found to be within normal range; -On call physician was attempted to be contacted but could not be reached; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Twenty minutes later the on call line was phoned again to contact a physician; -Staff did not document successfully contacting the physician or contacting the resident's responsible party. During an interview on 1/20/22 at 4:32 P.M., the resident's responsible party said no one from the facility informed him/her of an incident in mid-2021 that led to the resident being hospitalized . He/she said he/she was contacted by the hospital to come pick the resident up, but was never informed by the facility that the resident was sent out for evaluation or that any incident had occurred. During an interview on 1/25/22 at 1:59 P.M., the director of nursing (DON) and administrator said they expected nursing staff to notify a resident's responsible party in the event of a fall or hospitalization . They expected staff to notify a resident's first emergency contact, even if the resident was their own responsible party. MO00194059

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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** 37681 Based on observation and interview, the facility failed to provide a safe, clean and comfortable, homelike environment. The facility failed to repair pipes leaking outside of the facility's dining room and to address the sound levels of a heating unit in one resident's room (Resident #111). In addition, the facility failed to serve resident meals with appropriate dishware and utensils. The census was 121. 1. Observations on 1/18/22 at 1:08 P.M., 1/19/22 at 8:38 P.M., 1/20/22 at 12:34 P.M., and 1/21/21 at 7:20 A.M., showed two ceiling tiles missing in the hall leading to the dining room. Pipes leaked from the missing ceiling tiles, with mop buckets placed underneath them. During a group meeting on 1/20/22 at 2:00 P.M., four out of six residents said the plumbing has been an issue in the facility. Two ceiling tiles outside of the dining room are missing because the pipes underneath them leak and staff put buckets underneath them. The pipes outside of the dining room have been leaking for over a year and sometimes the pipes leak so much, the area outside of the dining room floods. The leaking pipes and flooding does not look nice. During an interview on 1/25/22 at 8:34 A.M., the maintenance director said the pipes had been leaking for a couple of months. He requested bids to have it fixed and was waiting on approval. The leaking pipes were not homelike for the residents. 2. Review of Resident #111's quarterly Minimum Data Set, (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/22/21, showed: -admitted on [DATE]; -Cognitively intact; -Exhibited no behaviors. Observation and interview on 1/18/22 at 1:41 P.M., showed the resident lay in bed, watching television. A loud humming noise came from the heating unit, near the window in the resident's bedroom. The resident said the noise was coming from the heating unit, and was extremely loud. The noise had been coming from the unit since he/she moved in the room in September 2021. Maintenance was aware of the issue. The noise bothered him/her and his/her roommates, but they had gotten used to it. Observation on 1/19/22 at 12:47 P.M., showed the resident in his/her room, reading over paperwork. A loud humming noise came from the heating unit. The resident's roommate asked the resident a question. The resident told the roommate to speak up because he/she could not hear over the heating unit. Observation on 1/20/22 at 5:55 P.M., showed the resident lay in bed on his/her back asleep. A loud humming noise came from the heating unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/25/22 at 8:34 A.M., the maintenance director said the noise in the resident's room was a motor mount that kept turning on and off. It had been broken for about two weeks. He ordered the part to have it repaired and was waiting for the part to be delivered to the facility. 3. Observations of the meal services on 1/18/22 at 12:46 P.M., 1/20/22 at 12:56 P.M. and 1/24/22 at 12:40 P. M., showed resident meals served in three compartment Styrofoam trays, with a plastic spoon, knife and fork. During an observation and interview on 1/21/22 at 11:45 A.M., the Dietary Manager said they had tons of silverware. She opened a file cabinet in her office with unopened boxes of knives, forks and spoons. During a group meeting on 1/20/22 at 2:00 P.M., five out of six residents said they were tired of being served meals in Styrofoam containers with plastic utensils. Sometimes the facility runs out of plastic utensils or residents receive the wrong type of utensils for certain foods. It is hard to cut certain foods, like meat, with plastic utensils. The facility has been out of plastic knives for a day. The other day, residents were served spaghetti with plastic spoons. Last night, there were no plastic forks. The use of plastic utensils is not homelike. During an interview on 1/25/22 at 7:14 A.M., the Dietary Manager said she was aware of residents complaining about the use of Styrofoam trays and plastic utensils. The facility had enough utensils for all residents, but they were using Styrofoam and plastic silverware because of Covid-19. 4. During an interview on 1/25/22 at 11:51 A.M., the administrator said the leaking pipes on the first floor was not considered home-like and they were in the process of having it repaired. She was not aware of the broken heating unit in Resident #111's room and the noise was not considered comfortable or homelike. The residents were served food in Styrofoam and with plastic silverware because of the Covid outbreak. MO00195088 40290

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to notify a representative of the State Long-Term Care Ombudsman of resident transfers/discharges for three of three residents sampled for emergency transfers (Residents #45, #2 and #78). The sample was 24. The census was 121. 1. Review of Resident #45's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, admission and discharge assessments, showed: -admitted [DATE]; -discharged to the hospital 10/18/21; -Readmission to the facility 10/25/21. 2. Review of Resident #2's MDS admission and discharge assessments, showed: -admitted [DATE]; -discharged to the hospital 11/3/21; -Readmission to the facility 11/5/21. 3. Review of Resident #78's MDS admission and discharge assessments, showed: -admitted [DATE]; -discharged to the hospital 12/15/21; -Readmission to the facility 12/18/21. 4. During an interview on 1/11/22 at 2:09 P.M., the director of the regional Ombudsman's office said the facility does not send monthly transfer notices. The Ombudman's office has not received monthly transfer notices from the facility since prior to June 2021. 5. During an interview on 1/25/22 at 2:39 P.M., the Social Services Director (SSD) said she started working with the facility on 12/13/21. Until this week, she was not aware she was responsible for notifying the Ombudsman's office of resident transfers from the facility. The Ombudsman's office should be notified of all resident transfers by the 15th of each month. She did not notify the Ombudsman's office of resident transfers in December 2021 because she was unaware she should. 6. During an interview on 1/24/22 at 7:20 A.M., the administrator said the SSD is responsible for notifying the Ombudsman's office of resident transfers from the facility. The Ombudsman's office should be notified on a monthly basis of all resident transfers. A discharge notification policy was requested. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	7. Review of an email on 1/28/22 at 8:06 A.M., showed the administrator documented the facility does not have a policy regarding notice of discharge/transfer.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to provide bathing and grooming assistance for two residents dependent on staff for assistance with hygiene maintenance (Residents #82 and #45). The sample was 24. The census was 121. 1. Review of Resident #82's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/10/21, showed: -admitted [DATE]; -Moderate cognitive impairment; -No behaviors exhibited; -Required extensive assistance of one person physical assist for bed mobility, dressing, toilet use and personal hygiene; -Total dependence of two (+) person physical assist for transfers; -Upper and lower extremity impairment on one side; -Diagnoses included stroke, coronary artery disease (CAD, heart disease), kidney failure, hemiplegia (paralysis affecting one side of the body), anxiety, depression and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). Review of the facility's shower schedule, undated, showed the resident's scheduled showers were on Monday, Wednesday, and Friday during the evening shift. Review of the resident's shower sheets from December 2021, showed: -Bed baths or showers completed 12/1/21 and 12/29/21. Staff documented the resident does not need his/her toenails cut; -No documentation of other bed baths or showers offered or provided. Review of the resident's shower sheets from 1/1/22 through 1/21/22, showed: -Bed bath or shower completed 1/17/22. Staff documented the resident does not need his/her toenails cut; -No documentation of other bed baths or showers offered or provided. Review of the resident's care plan, showed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: Resident has an activities of daily living (ADL) self-care performance deficit related to impaired balance, limited mobility; -Goal: No decline in ADL functioning through next review; -Interventions included one assist with transfers; -No documentation regarding the frequency of bathing/showering or hygiene preferences. Observation on 1/18/22 at 12:14 P.M., showed the resident on his/her back in bed, dressed in a hospital gown. His/her fingernails were long on both hands. His/her right big toenail measured approximately 1.25 centimeters (cm) above the top of the toe. During an interview, the resident said he/she had a stroke and is paralyzed on the left side. He/she cannot get out of bed without staff assistance and needs staff assistance with showers and personal care. His/her fingernails and toenails are long and he/she knows staff see them, but they haven't done anything about it. He/she does not want long fingernails or toenails. He/she received a shower this week, but it had been a long time since he/she was bathed before that. Observation on 1/19/22 at 12:45 P.M. and 1/20/22 at 12:39 P.M., showed the resident seated upright in bed with a hospital gown on. His/her fingernails were long and the right big toenail visibly protruded from underneath the sheet over the resident's legs. During an interview on 1/20/22 at 12:39 P.M., the resident said staff gave him/her a shower the previous day. When staff put him/her back in bed, the resident told staff about his/her long fingernails and toenails. The employee saw the resident's big toenail was about half an inch long and said they would be right back to trim them. The employee left the room and never came back. Resident could not recall the employee's name. During an interview on 1/24/22 at 10:08 A.M., certified nurses aide (CNA) G said the resident requires total assistance with bathing and one person to assist with transfers. He/she does not refuse care. Residents should be bathed or showered twice a week and as needed. While providing bathing assistance, staff should observe the resident's feet, skin and nails. CNAs can provide nail care for all residents unless they are diabetic. Diabetic residents receive nail care from the nurse. CNAs document bathing assistance on shower sheets. If a resident refuses bathing assistance, it should be documented on a shower sheet. During an interview on 1/24/22 at 9:16 A.M., Nurse B said residents should be bathed or showered twice a week and as needed. CNAs should follow the shower schedule and when they provide bathing assistance, they should observe a resident's skin, feet and nails. CNAs can trim a resident's nails, unless the resident is diabetic. If the resident is diabetic, nail care is performed by the nurse. The resident requires one staff to assist him/her with transfers and bathing. He/she does not refuse care. If a resident refuses bathing assistance, staff should document the resident's refusal on a shower sheet. 2. Review of Resident #45's annual MDS, dated [DATE], showed: -admitted [DATE]; (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Severe cognitive impairment; -No behaviors exhibited; -Total dependence of two (+) person physical assist for bed mobility, transfers, dressing toilet use and personal hygiene; -Upper extremity impaired on one side; -Lower extremities impaired on both sides; -Diagnoses included traumatic brain injury, deep venous thrombosis (DVT, blot clot formed in a deep vein), diabetes, aphasia (impairment of expression and understanding of language), seizures, dementia, quadriplegia (paralysis affecting all four limbs), and osteomyelitis (bone infection). Review of the facility's shower schedule, undated, showed the resident's scheduled showers were on Tuesday, Thursday, and Saturday during the day shift. Review of the resident's shower sheets from December 2021, showed: -Bed baths or showers completed 12/2/21, 12/14/21, and 12/16/21; -Bed bath or shower refused 12/23/21; -No documentation of other bed baths or showers offered or provided. Review of the resident's shower sheets from 1/1/22 through 1/21/22, showed: -Bed baths or showers completed 1/17/22 and 1/20/22. No documentation regarding nail care provided; -No documentation of other bed baths or showers offered or provided. Review of the resident's care plan, showed: -Focus: Requires total care with ADLs, diagnosis of quadriplegia, has history of resistance and aggressive behaviors at times during care; -Goal: Staff will anticipate resident's needs as needed, will be well groomed through next review; -Interventions included: -Inform resident of care to be provided prior, if becomes combative or resistant, leave alone and return later when calmer; -Total care with all ADL functioning; -Bathing/showering: Check nail length and trip and clean on bath day and as necessary. Report any changes to the nurse; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Contractures (tightening of muscles): The resident has contractures to bilateral lower extremities and feet and right arm. Provide skin care daily/as needed to keep clean and prevent skin breakdown; -No documentation regarding the frequency of bathing/showering. Observation on 1/18/22 at 12:10 P.M., showed the resident lay on his/her back in bed, dressed in a hospital gown. His/her right hand was contracted in a C-shape. His/her left hand had long fingernails, with the middle fingernail approximately 0.75 centimeters (cm) long. During an interview, the resident said he/she needs assistance from staff for bathing, dressing and getting him/her out of bed. He/she cannot move his/her legs. The resident was unable to recall the last time he/she was bathed or showered. Observation on 1/19/22 at 12:45 P.M. and 1/20/22 at 12:42 P.M., showed the resident seated upright in bed, dressed in a hospital gown with streaks of dried food and crumbs across his/her chest. The fingernails on the resident's left hand were long with the middle fingernail approximately 0.75 cm in length. Observation and interview on 1/20/22 at 5:57 P.M., showed the resident lay on his/her back in bed, dressed in a hospital gown with a sheet covering his/her legs. CNA N donned gloves and pulled the sheet off the resident's legs. The resident's legs bent at the knee, at approximately a 130-degree angle. The skin on both shins and calves appeared dry and flaky, with chunks of flakes on the sheet underneath the resident's legs. The entire bottom of both feet were covered with dozens of pencil-tip sized red areas covered with scabs. There were rust-colored streaks on the sheet underneath the resident's feet. CNA N said the resident's feet and legs looked dry, and he/she has always had sores on his/her feet. He/she thinks the nurse puts moisturizer on the resident's feet, but it doesn't look like it has been done recently. Residents should be bathed or showered every two days. CNAs document showers or bed baths on shower sheets. Because the resident's legs are dry, staff should put moisturizer on them after the resident is bathed. The resident is total care and likes bed baths or showers. During an interview on 1/24/22 at 10:08 A.M., CNA G said Resident #45 requires total assistance from staff with all ADLs, including bathing. He/she does not refuse bathing assistance and likes to be shaved, but might say no to being shaved on occasion. While providing bathing assistance, staff should observe the resident's feet, skin, and nails. CNAs can provide nail care for all residents unless they are diabetic. Diabetic residents receive nail care from the nurse. CNAs document bathing assistance on shower sheets. If a resident refuses bathing assistance, it should be documented on a shower sheet. 3. During an interview on 1/24/22 at 9:16 A.M., Nurse B said residents should be bathed or showered twice a week and as needed. CNAs should follow the shower schedule and when they provide bathing assistance, they should observe a resident's skin, feet and nails. CNAs can trim a resident's nails, unless the resident is diabetic. If the resident is diabetic, nail care is performed by the nurse. Resident #45 requires total care from staff for all of his ADLs. His/her legs are contracted and Nurse has not seen him/her out of bed during the last several months. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 1/25/22 at 7:06 A.M., the administrator and DON said they would prefer bed baths or showers to occur three times a week. Nursing staff is responsible for providing bathing assistance and they should follow the shower schedule as a guideline. If a resident refuses one day, staff should re-approach them later and try to determine a date or time that works for them. If the resident continues to refuse, the aide should get the nurse or Social Services involved to see if they can assist. When providing bathing assistance, staff should look at the resident's skin, feet and nails. CNAs can provide basic nail care and nurses can provide nail care for residents with diabetes or thick nails. The administrator was not aware residents were not provided with bathing assistance in accordance with the shower schedule.

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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** 40290 Based on observation, interview, and record review, the facility failed to provide one on one (1:1) activities for six of 23 residents who were identified as receiving 1:1 activities (Residents #45, #89, #82. #101, #115, #20, and #9). In addition, the facility failed to provide 1:1 activities for one resident identified by staff as having the desire to participate in 1:1 activities. The sample was 24. The census was 121. 1. Review of Resident #45's medical record, showed: -admitted [DATE]; -Diagnoses included traumatic brain injury, aphasia (impairment of expression and understanding of language), seizures, dementia, and quadriplegia (paralysis affecting all four limbs). Review of the resident's quarterly activity participation review, dated 9/6/21, showed: -Resident is on 1:1 with activity staff. Resident will refuse any activity offered, but will socialize with staff; -Resident likes when staff communicate with him/her and likes to watch television in his/her room, mostly lying in bed. He/she will listen to some music he/she enjoys. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident listed. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/8/21, showed: -Severe cognitive impairment; -Staff assessment of daily activities included listening to music, participating in favorite activities, and spending time outdoors; -Required staff physical assist for transfers and locomotion. Review of the resident's care plan, in use at the time if survey, showed the following: -Focus: Resident prefers to watch television in his/her room or in the sun room, he/she interacts with staff; -Goal: Activity level will remain the same without decline through next review; -Interventions: 1:1 visits from activities up to three times weekly; -Prefers to watch television in his/her room or in the sun room; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Prefers the following TV channels (specify): blank. Review of the resident's 1:1 activities documentation from 11/1/21 through 1/21/22, showed: -On 11/12/21 at 1:45 P.M., 1:1 visit conducted. The resident always has a good time when staff comes to see him/her. Listens to music and dances; -On 12/15/21 at 1:23 P.M., unable to conduct 1:1 visit because resident was asleep; -No documentation of additional 1:1 visits attempted or completed. Observation on 1/18/22 at 12:10 P.M., 1/19/22 at 8:11 A.M. and 12:45 P.M., 1/20/22 at 12:42 P.M. and 5:57 P.M., and 1/21/21 at 9:04 A.M., showed the resident seated upright in bed with the television on. Staff did not engage in activities with the resident. During an interview on 1/18/22 at 12:10 P.M., the resident said he/she stays in his/her room. He/she gets bored sometimes. Staff do not do activities with him/her. He/she would like visits from staff. 2. Review of Resident #89's medical record, showed: -admitted [DATE]; -Diagnoses included multiple sclerosis (nervous system disease that affects the brain and spinal cord), quadriplegia (paralysis of upper and lower limbs), heart failure, kidney failure, and depression. Review of the resident's significant change MDS, dated [DATE], showed: -No cognitive impairment; -Staff assessment of daily activities included listening to music and participating in favorite activities; -Upper and lower extremities impaired on both sides. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident listed. Review of the resident's quarterly activity participation review, dated 12/10/21, showed: -Resident refuses any scheduled activity. He/she does talk with activity staff and asks them to assist him/her with getting things for him/her while he/she is in bed in his/her room. Resident is on 1:1 with activity staff; -Resident prefers to be in his/her room. He/she enjoys watching television. Review of the resident's care plan, in use at the time if survey, showed the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focus: Resident mostly stays in his/her room with door closed at all times. He/she has history of getting nails trimmed or to the beauty shop to get hair washed or braided. Resident will accept some snacks from activity staff. He/she enjoys supernatural movies. Resident is at risk for alteration in psychosocial well-being related to restriction on visitation related to COVID-19 and medical status. He/she is withdrawn at times; -Goal: Resident will participate in more activities, will get out of bed at least twice a week; -Interventions included: 1:1 visits from activities up to three times weekly. Resident responds positively to music therapy. Play his/her choice of music at his/her request. Review of the resident's 1:1 activities documentation from 11/1/21 through 1/21/22, showed: -On 11/2/21, 1:1 visit conducted. Staff watched television with the resident. The resident can't move and feels a bit depressed; -On 12/8/21, 1:1 visit conducted. The resident was in a better mood today. He/she was watching television; -On 12/31/21, the resident was busy with a hospice visitor; -No documentation of additional 1:1 visits attempted or completed. Observation on 1/18/22 at 12:00 P.M. and 1/19/22 at 8:07 A.M., showed the resident lay on his/her back in bed. The television on. Staff did not attempt to engage with the resident. During an interview on 1/19/22 at 12:58 P.M., the resident said he/she relies on staff for assistance with all activities of daily living (ADLs) and depends on staff to transfer him/her out of bed. He/she spends all day in bed and watches television. He/she gets bored and is bored with the television. Staff never do activities with him/her and the resident is just left in his/her room. When asked how the resident is doing, he/she stated, Laughing on the outside, crying on the inside. 3. Review of Resident #82's medical record, showed: -admitted [DATE]; -Diagnoses included stroke, hemiplegia (paralysis of one side of the body), anxiety, and depression. Review of the resident's admission activity review, dated 6/18/21, showed the resident wishes to have 1:1 with staff. Review of the resident's admission MDS, dated [DATE], showed: -Severe cognitive impairment; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Very important to the resident to listen to music he/she likes, be around animals such as pets, keep up with the news, do his/her favorite activities, and go outside to get fresh air when the weather is good; -Somewhat important to the resident to do things with groups of people; -Required staff physical assist for transfers. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident not listed. Review of the resident's care plan, in use at the time if survey, showed the following: -Focus: Resident has little or no activity involvement related to anxiety and depression. He/she prefers to be in bed daily, watching television or asleep; -Goal: Resident will get out of bed at least two times a week through next review date; -Interventions: Encourage resident to get out of bed daily; -The care plan failed to identify the resident's group or individual activity participation level and desire to socialize. Observation on 1/18/22 at 12:14 P.M., 1/19/22 at 12:45 P.M., 1/20/22 at 12:39 P.M. and 5:56 P.M., and 1/24/21 at 8:57 A.M., showed the resident sat upright in bed with the television on. Staff did not engage in activities with the resident. During an interview on 1/18/22 at 12:14 P.M., the resident said he/she is paralyzed on his/her left side and requires staff assistance to get him/her out of bed. Staff don't always come help him/her out of bed and he/she spends a lot of time in his/her room. He/she gets bored in his/her room. Staff do not come by his/her room and do activities with him/her. Observation on 1/20/22 at 12:54 P.M., showed the resident lay on his/her back in bed. Staff did not engage in activities with the resident. During an interview, the resident said he/she had not received 1:1 activities. It would be nice for staff to come by and do activities with him/her. He/she likes to socialize and talk. 4. Review of Resident #101's medical record, showed: -admitted [DATE]; -Diagnoses included coronary artery disease (CAD), hypertension, diabetes, Alzheimer's disease, stroke, dementia, depression, and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves). Review of the resident's annual MDS, dated [DATE], showed: -Severe cognitive impairment; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff assessment of daily and activity preferences included participating in favorite activities; -Required staff physical assist for transfers and locomotion. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident listed. Review of the resident's quarterly activity participation review, dated 12/16/21, was left blank. Review of the resident's 1:1 activities documentation from 11/1/21 through 1/21/22, showed: -On 12/26/21, 1:1 visit not conducted. Resident was asleep. -No additional documentation of 1:1 visits conducted. 5. Review of Resident #115's medical record, showed: -admitted [DATE]; -Diagnoses included dementia, hemiplegia, seizure disorder, anxiety, depression, and psychotic disorder. Review of the resident's significant change MDS, dated [DATE], showed: -Resident rarely/never understood; -Staff assessment of daily and activity preferences included listening to music and participating in favorite activities; -Required staff physical assist for transfers. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident listed. Review of the resident's quarterly activity participation review, dated 12/20/21, was left blank. Review of the resident's 1:1 activities documentation from 11/1/21 through 1/21/22, showed: -On 11/1/21, 1:1 visit conducted. Resident was up looking at the TV and stated he/she wanted to go home. -On 12/17/21, 1:1 visit conducted. Staff and resident listened to music. -No additional documentation of 1:1 visits conducted. 6. Review of Resident #20's medical record showed: -admitted [DATE]; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included anemia, aphasia, cerebral palsy (a disorder affecting posture and motor function), dementia, quadriplegia, and seizure disorder. Review of the resident's annual MDS, dated [DATE], showed: -Resident rarely/never understood; -Staff assessment of daily and activity preferences included listening to music, being around animals such as pets, doing things with groups of people, participating in favorite activities, spending time outdoors, and participating in religious activities or practices. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident listed. Review of the resident's quarterly activity participation review, dated 10/26/21, was left blank. Review of the resident's 1:1 activities documentation from 11/1/21 through 1/21/22, showed: -On 11/3/21, 1:1 visit conducted. Staff played music for the resident to listen to. -On 11/18/21, 1:1 visit conducted. Staff noted the resident likes to watch television. -On 12/17/21, 1:1 visit conducted. Resident listened to music. -On 1/20/22, 1:1 visit conducted. Staff played music and the resident watched television. -No additional documentation of 1:1 visits conducted. 7. Review of Resident #9's medical record, showed: -An admitted [DATE]; -Diagnoses included anemia, CAD, hyperlipidemia, Alzheimer's disease, stroke, dementia, schizophrenia, bipolar disorder, and psychotic disorder. Review of the resident's annual MDS, dated [DATE], showed: -Resident rarely/never understood; -Staff assessment of daily and activity preferences included listening to music and participating in favorite activities. Review of the resident's quarterly activity participation review, dated 10/8/21, was left blank. Review of the facility's 1:1 activity visit list, revised 10/15/21, showed the resident listed. Review of the resident's 1:1 activities documentation from 11/1/21 through 1/21/22, showed: -On 1/5/22, 1:1 visit conducted. Staff noted the resident liked looking at the television. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No additional documentation of 1:1 visits conducted. 8. During an interview on 1/24/22 at 10:08 A.M., certified nurse aide (CNA) G said he/she knows Residents #45, #89, and #82 well. The residents cannot transfer on their own and are totally dependent on staff to assist them out of bed. All three of the residents are social and love to chat and talk with staff. CNAs talk with the residents while providing care, but the residents could benefit from 1:1 visits with activity staff. The CNA has not seen the residents receiving 1:1 activities. 9. During an interview on 1/24/22 at 9:16 A.M., Nurse B said Resident #45 and #89 are totally dependent on staff for transfers and mobility, and they are in bed most of the time. Resident #82 requires staff assistance to get out of bed and uses a wheelchair for mobility. Residents #25, #82, and #89 do not refuse care or assistance from staff. Each of the residents are social and like to interact with staff. The residents would benefit from 1:1 activities. The nurse has not seen the residents involved in 1:1 activities. 10. During an interview on 1/25/22 at 8:29 A.M., activity aide (AA) F said he/she works for the facility full-time. The facility had an Activity Director, but they quit last week. There are residents throughout the facility who receive 1:1 activities. 1:1 activities are also called friendly visits, and they are provided to residents who don't like going to group activities or they can't get out of bed. 1:1 activities are supposed to be provided three times a week. They are not getting done as often as they should because the activity aides get pulled to the floor to assist with other things, like monitoring the hall. If a resident is asleep when activity staff attempt to visit, staff should try to come back later. The activity aides document their 1:1 visits on the 1:1 sheets. Resident #45 enjoys his/her 1:1 activities and likes to sing and play music. Resident #89 also participates in activities and likes to watch television with staff and play music. Resident #82 does not receive 1:1 activities, but the resident is mostly in bed all the time and could benefit from 1:1 visits. 11. During an interview on 1/25/22 at 9:01 A.M., the administrator said the Activity Director just quit last week. The facility currently has two activity aides. The activity aides are responsible for providing 1:1 activities. 1:1 activities should be offered at least three times a week. She was not aware 1:1 activities were not being provided three times a week. If staff attempt to offer 1:1 activities, but a resident is sleeping, the staff should try again another time. 1:1 activities should focus on what a resident likes to do, such as drawing, walking, or listening to music. Residents who might not like crowds or who are bed bound are referred to 1:1 activities. Involvement in activities could help improve a resident's quality of life. During an interview on 1/25/22 at 1:01 P.M., the administrator said the facility does not have a policy regarding activities. 44948

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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** 40290 Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one resident identified with a rash on his/her feet. The facility failed to clarify physician orders for treatment, to administer treatments as needed, and to notify the physician upon a change in condition when the resident developed an abrasion on his/her feet (Resident #45). The sample was 24. The census was 121. Review of the facility's Non-Pressure Skin Evaluation policy, revised 12/2019, showed: -General: To provide guidance on the evaluation of skin tears, bruises, and rashes; -Responsible party: Licensed Nursing Staff, Wound Care Coordinator, Treatment Nurse; -Policy: When a resident is identified as having a skin tear, bruise, rash, or other skin condition, the appropriate documentation is completed including notification of physician and resident representative per facility guideline. Once the documentation is completed, a corresponding care plan is developed, if needed; -Procedure: -Skin tear: -When a resident is identified with a skin tear, the physician and resident representative are notified, and the appropriate documentation is completed; -Follow the policy and procedure of the treatment guidelines; -Document treatment in the electronic health record (EHR); -Update plan of care to reflect current skin management needs; -Rashes: -When a resident is identified with a rash, the physician and resident representative are notified, and the appropriate documentation is completed; -The Director of Nursing (DON) or designee and the Wound Care Coordinator or designee, will collaborate on rashes to determine if the Wound Care department will follow in Wound Rounds; -Only rashes that are followed by the Wound Care department, such as fungal and rashes with drainage, will be monitored using the Wound Rounds system; -Document treatment in EHR; -Update plan of care to reflect current skin management needs; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Types of rashes could include: -Infectious: ringworm, impetigo, fungal, virus, parasites; -Noninfectious: eczema, contact dermatitis, drug erupts, hives. Review of Resident #45's medical record, showed: -admitted [DATE]; -Diagnoses included traumatic brain injury, deep venous thrombosis (DVT, blot clot formed in a deep vein), diabetes, aphasia (impairment of expressing and understanding language), seizures, dementia, quadriplegia (paralysis affecting all four limbs) and osteomyelitis (bone infection); -No weekly nurse's skin assessments documented in October 2021. Review of the resident's physician order sheet (POS), showed an order, dated 10/26/21, for triamcinolone acetonide cream (topical steroid) 0.1%, apply to affected area topically every 8 hours as needed for affected area, dry flaking skin. The order did not specify the affected area; Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/8/21, showed: -Severe cognitive impairment; -No behaviors exhibited; -Total dependence of two (+) person physical assist required for bed mobility, transfers, dressing toilet use, and personal hygiene; -Upper extremity impaired on one side; -Lower extremities impaired on both sides; -At risk of developing pressure ulcers; -No skin issues; -Skin and ulcer treatments include pressure-reducing device for bed, applications of ointments/medications other than to feet. Review of the resident's pressure ulcer risk assessment, dated 11/10/21, showed the resident identified as high risk for developing pressure ulcers. Further review of the resident's medical record, showed: -Shower sheets completed 11/2/21, 11/4/21, 11/6/21, 11/9/21, 11/11/21, 11/13/21, 11/16/21, and 11/30/21, showed no skin issues identified; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No weekly nurse's skin assessments documented in November 2021; -A medication administration record (MAR) and treatment administration (TAR) for November 2021, showed triamcinolone acetonide cream not documented as administered; -Shower sheets completed 12/2/21, 12/14/21, 12/16/21, and 12/18/21, showed no skin issues identified; -No weekly nurse's skin assessments documented in December 2021; -The MARs and TAR for December 2021, showed triamcinolone acetonide cream not documented as administered. Review of the resident's progress note, dated 1/4/22 at 7:49 A.M., showed Nurse P documented noting several tiny blood tinged stains on the resident's sheets. Upon assessing, nurse noted both feet with redness, scaly sores present, and small amount of bloody drainage. Right heel with multiple areas and scab formation. Oncoming nurse and Director of Nurses (DON) notified. Further review of the resident's medical record, showed no physician notification of the scabbed areas, identified on 1/4/22. Review of the resident's weekly nurse's skin assessment, dated 1/5/22, showed Nurse B documented the resident identified with an abrasion to the right heel, might be caused from friction from bed sheets. Dry skin to bilateral feet, and rash to bottom of both feet. Review of the facility's general wound report, dated 1/5/22, showed the resident was not listed. Further review of the resident's medical record, showed: -No measurements of the abrasion noted on 1/5/22; -No physician notification of the abrasion noted on 1/5/22; -No weekly nurse's skin assessments documented after 1/5/22; -A shower sheet, dated 1/17/22, showed no skin issues identified; -The MAR and TAR for January 2022, showed triamcinolone acetonide cream not documented as administered 1/1/22 through 1/19/22. Review of the resident's care plan, showed: -Focus: Resident has rash area to his/her right foot. 10/1/19 rash to left foot, diagnosis of varicosities of extremities; -Goal: Resident will have no signs or symptoms of infection of the rash through the review date; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Monitor skin rashes for increased spread or signs of infection. Treatment as ordered, inform physician if treatment plan is unsuccessful; -Focus: Resident requires total care with activities of daily living (ADLs), diagnosis of quadriplegia and history of resistance and aggressive behaviors at times during care; -Goal: Staff will anticipate resident's needs as needed, will be well groomed through next review; -Interventions included: Total care with all ADL functioning. Resident is totally dependent on 1-2 staff for repositioning and turning in bed at least two hours and as necessary. The resident has contractures (tightening of muscles) to bilateral lower extremities and feet. Provide skin care daily/as needed to keep clean and prevent skin breakdown. Skin inspection daily, observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. Observation on 1/18/22 at 12:10 P.M., showed the resident lay in bed on his/her back. During an interview, the resident said he/she needs assistance from staff for bathing, dressing, and getting him/her out of bed. He/she cannot move his/her legs. Observation and interview on 1/20/22 at 5:57 P.M., showed the resident on his/her back in bed, dressed in a hospital gown with a sheet covering his/her legs. The resident agreed to a skin assessment of his/her legs and feet. Certified nurse aide (CNA) N donned gloves and pulled the sheet off the resident's legs. The resident's legs bent at the knee, at approximately a 130-degree angle. The skin on both shins and calves appeared dry and flaky, with chunks of flakes on the sheet underneath the resident's legs. The entire bottom of both feet were covered with dozens of pencil-tip sized red areas covered with scabs. A pencil eraser-sized, round scab on the resident's left heel, and two pencil eraser-sized scabs on the resident's right heel, with dried blood smeared on both heels. Rust-colored streaks on the sheet underneath the resident's feet. CNA N said the resident's feet and legs looked dry, and he/she has always had sores on his/her feet. The CNA was not sure what the sores were. He/she thinks the nurse puts moisturizer on the resident's feet, but it doesn't look like it has been done recently. Residents should be bathed or showered every two days. CNAs document showers or bed baths on shower sheets. They should notify the nurse of any new skin issue identified and mark any skin issues on the shower sheet. Because the resident's legs are dry, staff should put moisturizer on them after the resident is bathed. The resident needs total care and likes bed baths or showers. Observation and interview on 1/20/22 at 6:14 P.M., showed the resident on his/her back in bed with a sheet covering his/her legs. Assistant Director of Nurses (ADON) O said it was her first day working at the facility and she did not know the resident. ADON O donned gloves and pulled the sheet off the resident's legs. She could not identify the scabbed areas to the bottom of the resident's feet. She expected CNAs to provide bathing assistance twice a week. The CNAs should note any skin issues on the resident's shower sheet and notify the nurse of any new areas. She expected nurses to perform skin assessments every week and document their findings in the medical record. If the nurse observed a new skin area, they should notify the physician and obtain orders for treatment. Physician communication should be documented in the resident's medical record. (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 1/24/22 at 9:16 A.M., Nurse B said residents should be bathed or showered twice a week and as needed. CNAs should follow the shower schedule and when they provide bathing assistance, they should observe a resident's skin and feet, and note any abnormalities on the shower sheet. CNAs should also notify the nurse of any new skin issues. Typically, nurses should perform skin assessments on a weekly basis, but there is no current schedule or mechanism in place for nurses to complete and document their skin assessments. Resident #45 requires total care from staff for all of his ADLs. His/her legs are contracted and Nurse B has not seen him/her out of bed during the last several months. When Nurse B identified the abrasion on the resident's heel on 1/5/22, he/she did not obtain measurements because the area was not open and there was no drainage. He/she thinks he/she spoke to the physician about the area, and the physician said to apply cream. The resident already has an order in place for triamcinolone acetonide, as needed. The physician order should specify where the cream should be applied so other nurses will know, and the cream should be applied to the resident's feet. Based on the resident's current condition of a scabbed rash on his/her feet, staff should have been applying triamcinolone acetonide cream to the area. Treatment administration should be documented on the TAR. Nurse B did not find his/her communication with the physician in the resident's EHR. Some notes from the EHR disappear. Nurse also notified the treatment nurse about the resident's new area to his/her heel. During an interview on 1/25/22 at 7:06 A.M., the administrator and DON said they would prefer bed baths or showers to occur three times a week. Nursing staff is responsible for providing bathing assistance and they should follow the shower schedule as a guideline. When providing bathing assistance, staff should look at the resident's skin, feet, and nails. If there are any skin issues, staff should notify the nurse and document their findings on the resident's shower sheet. During an interview on 1/28/22 at 9:32 A.M., the administrator and DON said they expect all skin issues, including rashes and dryness, to be documented on resident shower sheets. Resident #45's physician order for triamcinolone acetonide, as needed, should have been applied when staff noted the rash on his/her feet. Skin treatments should be applied consistently, until the area clears up. The order for triamcinolone acetonide should specify to which area the medication should be applied. Nurses should clarify orders like this with the physician. When a nurse becomes aware of new skin issues, they should notify the resident's physician to obtain treatment orders. When Resident #45 was noted with a new abrasion to his/her right heel on 1/5/22, the nurse should have obtained measurements of the abrasion and provided more detail as to its appearance. The administrator and DON expected the nurses to notify the physician and wound nurse of the new skin area to obtain treatment orders, and the notification should have been documented in the resident's medical record.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29948 Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent and implement appropriate interventions for one resident who experienced a fall resulting in a fractured wrist and shoulder (Resident #8) due to the staff leaving the resident's side. In addition, the facility failed to provide adequate supervision for an elopement (leaving the premises or a safe area without authorization and/or any necessary supervision to do so) from a secured unit (Resident #32). In addition, the facility failed to provide oversight for one resident with a history of falls (Resident #82). The facility failed to ensure the residents environment remained free of accident hazards when staff failed to ensure the soiled utility room, where hazardous material is stored, was locked and inaccessible to residents. Also, the facility failed to complete a smoking assessment for one resident (Resident #43). The sample was 24. The census was 121. 1. Review of the facility's Fall Evaluation and Prevention policy, revised 8/2020, showed: -Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents; -Policy: The facility will evaluate residents for their fall risk and develop interventions for prevention. The goal is to prevent falls if possible and avoid any injury related to falls. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed; -Intervention suggestions for fall prevention included place bed in lowest position and lock wheels; -Education of staff related to fall prevention, includes: -Providing a safe environment for residents; -Cause and risk factors for falls as well as the interventions to manage risk; -Safe transferring techniques; -Use of assistive devices. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 10/5/21, showed: -No cognitive impairment; -Total dependence of two (+) person physical assist required for bed mobility, transfers, locomotion; -Total dependence of one person physical assist required for toilet use; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Required extensive assistance of one person physical assist for personal hygiene; -No upper or lower impairment; -Diagnoses included end stage renal disease (ESRD, kidney disease), high blood pressure, seizures, anxiety, depression, bipolar disorder (a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks), schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), insomnia, restlessness and agitation and repeated falls; -One fall with injury since last assessment. Review of the resident's quarterly fall risk assessment, dated 11/23/21, showed the resident identified as moderate risk for falling. Review of the resident's progress notes, dated 12/18/21, showed: -At 7:12 A.M., at 4:52 A.M., nurse called to room by CNA. Observed resident on bed, right side, dangling off bed. CNA stated he/she went to wet his/her towels and the resident rolled. Resident assessed, bed lowered, and resident was able to roll back onto bed. Range of motion to upper extremities, complained of discomfort when resident's left arm extended. Given Tramadol (pain medication). Scheduled for dialysis this morning, leave of absence to dialysis; -At 11:01 A.M., it was reported the resident was hanging on the side of the bed and complained of his/her left elbow hurting. Resident went out to dialysis. Physician notified of incident and that resident received Tramadol for pain. Received call from dialysis and informed that resident requested to go to the emergency room (ER) for complaint of left arm and hip pain. Resident transferred to ER from dialysis. Time of call was 9:11 A.M; -At 3:13 P.M., report received from ER. Resident had fracture to left shoulder and left wrist. Resident will return to facility with left shoulder splint. Resident also has urinary tract infection (UTI) and will be on antibiotics; -At 5:40 P.M., the resident returned to the facility from the hospital with a fractured left shoulder and left wrist. Sling in place. Resident stable with minimal pain. Physician notified of resident's return and medications verified. Review of the facility's investigation form, signed by the DON on 12/19/21, showed: -Date and time of occurrence: 12/18/21, 6:59 A.M.; -Detailed description of original allegation/event: Staff nurse was called to room by assigned CNA. While activities of daily living (ADL) care was being provided, the CNA walked to wet a towel when this resident rolled onto the right side, dangling out of the bed; -Assessment of resident/description of injury: Left arm pain; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident interview summary: Resident reported he/she tried to turn while the CNA went to walk away; -Immediate resident protection initiated: Resident's bed was moved along the side of the wall. Half side rails were intact and floor mat on the floor; -Summary of investigation findings: Resident rolled onto right side of bed, dangled along the side of the bed. Was assisted onto the bed. While staff was assessing this resident's range of motion, resident complained of pain to left arm. Pain management was given prior to this resident leaving for scheduled dialysis appointment. Review of the resident's care plan, showed: -Focus: On 6/1/20, resident lowered to floor by staff. Resident has history of leaning to left side while in bed. On 8/11/21, rolled out of bed onto the floor, attempted to get money off of the floor. Noted bruise to head; -Goals: Resident will call when he/she needs assistance with ADLs. He/she will remain free from injury related to poor ADL mechanics; -Interventions included bed in lowest position, side rails removed, mat placed on floor to left side. Two person assist with transfers; -Focus: Resident has limited physical mobility related to weakness, has poor trunk control, history of leaning to left side of bed, history of refusing to get out of bed; -Goals: Resident will remain free of complications related to immobility, including fall related injury through next review date. Resident will maintain current level of mobility transfer with two assistance using a gait belt from surface to surface. He/she refuses to transfer using a Hoyer lift; -Interventions included: Hoyer lift (mechanical lift) for transfers. Staff position resident for proper alignment while in bed. Resident requires assistance of two staff members and a gait belt for transfers. -Focus: 12/18/21 fractured to left proximal humerus (portion of the arm bone between shoulder and elbow, closest to the shoulder) and left distal radius (end portion of the forearm, closest to the wrist) fracture; -Interventions included: No weight bearing status to left arm, maintain left shoulder in sling. Bed in lowest position when not providing care. Don't leave unattended with side rails down. Left hand brace. Mat to left side of bed. Two person assist with transfers. -Focus: Resident is at risk for falls. Resident keeps bed in a high position and needs reminders to call for help; -Goals: Resident will be free of injury related to falls; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Interventions: Educate on fall risk as needed. Two quarter-length side rails to aide in bed mobility and repositioning. Encourage resident to keep bed in low and locked position. Two person assist with transfers; -The care plan did not specify type of staff assistance and number of staff required for personal care and toileting. Observation on 1/18/22 at 1:01 P.M., showed the resident on a stretcher, wheeled into his/her room by two staff. Staff used a sliding board to transfer the resident from the stretcher to his/her bed. Staff raised a quarter-length side rail on the left side of the resident's bed, and left the room. The right side of the resident's bed was flush to the wall. The resident's bed was positioned approximately 3 feet above the floor. No fall mat was on the floor. The resident's left wrist was in a brace. During an interview, the resident said he/she fell out of bed recently because the bed was too high. When he/she fell , his/her left wrist hit the air-conditioning unit. Observation on 1/19/22 at 12:54 P.M., showed the resident lay on his/her back in bed with a quarter-length side rail raised on the left side of the bed. The resident's bed was positioned approximately 3 feet above the floor. No fall mat was on the floor. Observation on 1/20/22 at 12:28 P.M., showed the resident seated upright in bed with a quarter-length side rail raised on the left side of the bed. The resident's bed was positioned approximately 3 feet above the floor. No fall mat was on the floor. During an interview on 1/25/22 at 7:19 A.M., the DON and administrator said prior to Resident #8's fall on 12/18/21, the resident required one person to assist with personal care. The DON said she investigated the resident's fall. During the investigation, the DON discovered the CNA walked away from the resident while the resident's bed was raised in a high position. Before providing care, CNAs should gather all materials needed before they enter the resident's room. If the CNA forgot something, they should have called for another employee to come help them. At minimum, the resident's bed should have been lowered when the CNA walked away. 2. Review of the facility policy, titled Elopement Prevention, revised 7/2021, defined elopement as having occurred when a resident left the facility without the expressed knowledge or approval of the facility or an authorized representative of the facility. The Centers for Medicare and Medicaid Services (CMS) defined elopement as leaving the facility premises or a safe area without authorization such as an order for discharge or leave of absence. Residents identified as being at risk for elopement were to have an individualized plan of care developed and implemented which attempted to reduce their elopement or flight risk. In response to an actual elopement attempt, if staff placed the resident on increased supervision, then they were to document safety checks in the clinical record/electronic medical record (EMR) each shift for the duration of the increased supervision. Review of Resident #32's wandering/elopement assessment, dated 8/2/21, showed the resident was assessed as having the potential/being at low risk for wandering or elopement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's undated diagnosis sheet, included the following diagnoses: schizophrenia, paranoid schizophrenia (a subtype of schizophrenia characterized by the presence of auditory hallucinations or prominent delusional thoughts about persecution or conspiracy), restlessness and agitation, sexual disorders, mood [affective] disorder (a mental health disorder in which a person experiences long periods of extreme happiness, extreme sadness or both), intellectual disabilities, problems related to lifestyle (self-damaging behavior) and sexual dysfunction not due to a substance or known physiological condition. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/4/21, showed the following: -Cognitively intact; -Psychosis: hallucinations; -Wandering behavior occurred one to three days; -Required supervision of one for locomotion off of the unit; -No mobility devices. Review of the resident's care plan, showed no identified elopement risk or preventative interventions. Review of the resident's progress note, dated 1/5/22 at 10:10 P.M., showed the resident kept going to the door, saying he/she was going to leave. Staff redirected the resident to his/her room several times. The resident went back to the door, so the nurse called the resident's parent to inform him/her of the resident's behavior. The resident told the responsible party that the resident no longer wanted to be at the facility. The resident agreed to go back to his/her room. At 11:13 P.M., the administrator received a call from staff saying the resident was returned to the facility by his/her parent, who said the resident described getting out of the locked unit behind a worker. The resident, who was alert and oriented times two (to person and place), did not exhibit any signs of distress and had no bruises, scratches or discolored skin. Review of MapQuest.com showed the resident walked 1.2 miles to the store. Review of the weather history for 1/5/22 at 9:51 P.M., showed the temperature was 21 degrees Fahrenheit. Further review of the resident's care plan, updated 1/6/22, showed the following: -The resident had a guardian; -Psychiatric consult as needed; -At risk for falls related to potential adverse effects from taking medications to manage symptoms of schizophrenia and hypersexuality (pathologically increased sexual behaviors/obsessive fixation on sex); (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident could be resistant to care and required redirection from making sexual remarks toward staff; -1/6/22, episode of elopement related to the resident being anxious (stating he/she wanted to get out of the facility). Review of the facility's investigation form, dated 1/11/22, showed on 1/5/22 at about 10:00 P.M., certified medication technician (CMT) R last saw the resident at or around 10:00 P.M. No alarm sounded on the unit, indicating that someone left the unit. The night supervisor saw a woman walking into the facility and asked if she needed help, the woman said that between 10:31 P.M. and 10:38 P.M., a store clerk had called and put the resident on the phone. The resident asked to be picked up. The woman was returning him/her to the facility. She said the resident appeared to be anxious. The two CMTs later said they heard the resident speaking about wanting a girlfriend. They denied hearing the resident mention that he/she wanted to leave the facility or saying he/she was going to leave. The certified nurse aide (CNA) on duty in the unit did not interact with the resident during the entire shift. The resident said he/she was mad, because the the girls were breaking his/her heart, he/she needed to get out and clear his/her mind. After eloping, the resident got cold while walking, went to Walgreens and asked the store clerk to call his/her parent. The resident said he/she did not tell anyone he/she hated the facility and was going to leave, that the elopement was unplanned. During an interview on 1/20/22 at 2:45 P.M., CMT Q said on the night in question, the other CMT left for the night at 8:00 P.M. A little before 10:00 P.M., the resident started going back and forth, to the doors leading out of the unit. He/she did it three times. The resident was saying that he/she wanted leave the facility and go home. Staff tried to redirect him/her, but the resident said he/she did not want to be there anymore. It was the first time, in CMT Q's three months working at the facility, that CMT Q heard the resident express the desire to leave. At 9:45 P.M., staff got the resident's family member on the phone, to assist in their efforts to redirect the resident, by allowing the resident to speak to him/her. CMT Q last saw the resident at around 10:15 P.M. After walking the resident to his/her room, CMT Q went to the bathroom and then sat at the nursing station for the remainder of his/her shift. He/she was gathering his/her things, preparing to go home, when the nursing supervisor escorted the resident back onto the unit at around 11:05 P.M. During an interview on 1/19/22 at 1:05 P.M., Nurse R said he/she was not familiar with the resident. On the night in question, there were four staff members on duty in the unit: Nurse R, two CMTs and a CNA. The resident kept coming up to the nurse's station to talk and asking about dinner. After dinner, at around 8:00 P. M., the resident started going to the doors leading out of the unit. He/she did that two or three times, looking out through the windows in the doors. The last time he/she went to the doors, he/she did not seem to want to come away from them. Someone suggested having the resident talk to his/her parent. At that point, he/she was not upset. Nurse R only heard the resident say something about leaving to his/her family member over the phone. Nurse R heard the resident say that he/she wanted to go home. After that phone call, the resident went to his/her room. That was the last time Nurse R saw the resident, prior to his/her elopement. Nurse R sat at the nurse's station with CMT Q throughout the remainder of the shift and charted. Nurse R had only gotten up once to use the bathroom at around 9:00 P.M. Nurse R was shocked when the night supervisor returned the resident to the unit, saying his/her family member picked the resident up from a store. Nurse R had not seen the resident leave the unit and did not know he/she was gone. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/18/22 at 2:15 P.M., the resident said he/she was upset on the night of his/her elopement, but did not recall expressing to staff the intent to leave. He/she just saw a female staff person (name unknown) leaving and followed her out of the locked unit. The resident was able to get to the first floor unobserved and walked past the security guard seated at the receptionist desk (when the guard was looking down) and exited the facility via the front door. During an interview on 1/28/22 at 2:56 P.M., the Director of Nursing (DON) said when a resident expressed the intent to leave a secure unit and engaged in behaviors such as repeatedly going to the doors leading out of the unit despite redirection, staff were expected to put the resident on 15 minute checks and notify the receptionist at the front desk. There should be photographs of all residents, identified as being at risk for elopement, posted at the receptionist desk. The increased level of supervision should continue, as long as the behaviors and expressed desire to leave continued. During an interview on 1/25/22 at 8:13 A.M., the administrator said the facility alarms and door locks were tested and were fully functional. When a resident on a secured unit expressed the intent to leave and/or repeatedly went to the doors leading out of the unit, it was the responsibility of staff on the unit to ensure the resident did not continue to stand by the doors and maintain line-of-sight supervision or increase monitoring to 15 minute checks. One out of the four staff on duty on the unit said the resident was at the door, saying he/she wanted to leave. None of them admitted to the resident exiting the unit behind them. They each said they had gone to the bathroom and consequently did not see the resident elope or know the resident was missing, until his/her return to the unit. Seated at the receptionist desk near the facility entrance was a security guard, contracted via a private security company, who was so hard of hearing that one had to stand in front of him/her and shout in order to be heard. The security guard did not see the resident walk out of the facility. As a contracted security guard, he/she would not have known if someone leaving was a visitor or resident, since there was no cut off time at night for visitation and there was not enough time to thumb through the elopement book every time someone left. After the resident eloped, the facility began posting pictures at the receptionist desk of residents at risk for elopement. The resident was at risk for harm, out in the community unsupervised, due to his/her cognitive impairment and mental health issues. During an interview on 1/24/22 at 2:54 P.M., Psychiatric Nurse Practitioner (NP) S said he/she was new to the facility and had not yet met the resident due to the facility Covid lockdown and NP S recently contracting Covid. NP S had performed a chart review. Part of the resident's cognitive impairment impacted his/her impulsivity, judgment, personality and the reward system in the brain. Consequently, the resident had no insight and poor judgment. He/she also had a history of sexually inappropriate behavior. The resident was very much so at risk for harm out in the community unsupervised due to the cognitive impairments and poor judgment posing a risk for him/her engaging in risky and/or impulsive behaviors. The resident was childlike and consequently could be induced to do things that the average person would not do. The resident's behaviors of saying he/she wanted to leave and repeatedly going to the doors leading out of the unit warranted one-to-one staff supervision. 3. Review of Resident #82's medical record, showed: -admitted [DATE]; -Diagnoses included stroke, hemiplegia (paralysis of one side of the body), depression and anxiety; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-A quarterly fall risk assessment, dated 9/16/21, showed the resident identified as high risk for falling. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Required extensive assistance of one person physical assist for bed mobility; -Total dependence of two (+) person physical assist for transfers; -Upper and lower extremities impaired on one side; -Two or more falls since last assessment. Review of the resident's care plan, showed: -Focus: Resident is at risk for falls. Gait/balance problems, diagnosis of stroke with left side weakness. Resident is non-ambulatory. On 6/29/21, noted on the floor with no injuries. On 9/27/21, reported he/she fell out of bed. On 10/2/21, noted on mat next to bed with no injuries; -Goals: Resident will not have significant injuries related to falls through next review; -Interventions included mat to right side of bed. Observation on 1/18/22 at 12:14 P.M., showed the resident seated upright in bed. No fall mats were on the floor. During an interview, the resident said he/she is paralyzed on the left side and requires staff to assist with transfers. He/she has had a million falls, and none resulted in injury. Observation on 1/18/22 at 1:23 P.M., 1/19/22 at 12:45 P.M., 1/20/22 at 12:39 P.M. and 5:56 P.M., and 1/21/21 at 7:27 A.M., showed the resident in bed. No fall mats were on the floor. During an interview on 1/24/22 at 10:08 A.M., CNA G said he/she works at the facility full time and knows the residents well. He/she requires one staff to physically assist with transfers and he/she requires total care for other ADLs. CNA G was not sure if the resident had a history of falls or requires fall interventions, such as a fall mat. The resident is always in bed when he/she is not at dialysis. He/she requires two people to assist with repositioning and personal care. Before providing personal care, staff should gather all items needed in advance, such as a water basin, towels, soap, clothes and bags. During care, they might have to raise a resident's bed in order for staff to reach them. When care is completed, staff should lower the resident's bed. Staff should not leave a resident in a bed raised in a high position because the resident could roll and fall. If a resident is at risk for falls, staff should place a fall mat next to their bed when they are finished providing care. Residents have care plans in their electronic medical record, but CNAs are informed of fall interventions when they receive report from the nurse. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/24/22 at 9:16 A.M., Nurse B said Resident #82 requires staff assistance with transfers and ADL care. He/she had a fall from his/her wheelchair, but the nurse could not recall if there were any other falls. The resident has side rails as a fall intervention. He/she has a history of falls, usually because he/she rolls over when trying to reach something. The resident does not get out of bed too much. He/she requires one staff person to assist him/her with personal care and bed baths. When staff is going to provide care, they should prepare everything in advance and gather their supplies, such as towels and ointments. If everything is ready in advance, staff would have no reason to leave a resident unattended. If staff need assistance or additional items during care, they should call for help. It would not be appropriate to walk away while a resident is in a bed raised in a high position. The resident's fall interventions include a fall mat, side rails, and keeping the bed in a low position. Interventions are reflected on a resident's care plan. Fall interventions and care needs are communicated to CNAs during report. During an interview on 1/27/22 at 12:04 P.M., the resident's physician/facility medical director said he expected staff to always put a resident in a safe position before leaving the room. The aide should have ensured the resident was in a secure position before leaving. His expectation is for staff to follow the resident's care plan for interventions, put in place by the facility. 4. During an interview on 1/25/22 at 7:19 A.M., the DON and administrator said following a resident's fall, the interdisciplinary team (IDT) gets together to discuss appropriate interventions. Old interventions are assessed to see what worked and what did not. They try to identify the root cause of a resident's fall so they can put the proper interventions in place. Fall interventions are documented on the resident's care plan and should be resident-specific. The care plan is updated by the MDS coordinator or nurses. Fall interventions are communicated to department heads during the weekly IDT meetings, and when the charge nurse gets report before each shift. 5. Review of the facility's Sharp Object Disposal policy, reviewed 7/2014, showed: -General: All sharps including needles, syringes, scalpels, and razors are disposed of in an appropriate sharps container; -Guidelines: 1. All sharps are dropped into the sharps container needle first. Never cut or recap a needle; 2. Never place your hand in a sharps container; 3. When a sharps receptacle is 3/4 full, the nurse is responsible for alerting the responsible department to replace the container, or to replace the container themselves; 4. When the new sharps receptacle is replaced, make sure it is secured into place and the opening is facing outward; 5. If the nurse is responsible for removing the filled sharps receptacle, place the receptacle in the designated place for appropriate storage based on state and federal guidelines. Review of the facility's census report, dated 1/18/22, showed 39 residents occupied the first floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation of the first floor on 1/18/22 at 11:59 A.M., showed the soiled utility room door open with no staff present. Three uncovered trashcans were filled with soiled linens. A red biohazard tub was open and filled with an overflow of full sharps containers, approximately 6 inches above the top of the biohazard tub opening. Observation of the first floor on 1/19/22, showed: -At 6:44 A.M., the soiled utility room door open with no staff present. Two trash bags were filled with soiled linens and four full sharps containers in an open biohazard tub; -At 12:42 P.M., the soiled utility room door open with no staff present. Three uncovered trashcans were filled with soiled linens. A red biohazard tub was open and filled with full sharps containers. The top sharps container was uncovered and filled with syringes and other materials; -At 12:46 P.M., CNA G entered the soiled utility room and dropped soiled linens into a trashcan. He/she pulled the door as he/she exited the room and left the door ajar; -At 12:52 P.M., CNA H opened the soiled utility room door and allowed a resident to enter the room while the CNA supervised. The resident exited and CNA shut the door all the way. Observation of the first floor on 1/20/22 at 12:21 P.M., showed the soiled utility room with two uncovered trashcans filled with soiled linens. A red biohazard tub was open and filled with an overflow of full sharps containers, approximately eight inches above the top of the biohazard tub opening. CNA G entered the soiled utility room and dropped soiled linens into a trashcan. He/she exited the room and left the door ajar. At 12:38 P.M., CNA G entered the soiled utility room and dropped off soiled linens. He/she closed the door upon exiting the room. During an interview on 1/24/22 at 10:08 A.M., CNA G said the soiled utility room is hazardous because it is where used sharps and soiled linens go. The soiled utility room should be locked at all times and inaccessible to residents due to safety reasons. Upon exiting the soiled utility room, staff should make sure the door closes behind them. During an interview on 1/24/22 at 9:16 A.M., Nurse B said used razors and syringes are placed in sharps containers. When sharps containers are full, the nurses put them in a red biohazard tub in the soiled utility room. Sharps containers should be locked. Residents should not have access to the soiled utility room due to the hazardous materials stored in the room. Staff must ensure the door to the soiled utility room closes behind them. During an interview on 1/25/22 at 7:19 A.M., the DON and administrator said used razors and syringes are disposed of in sharps containers. When the sharps container is full, it should be locked and placed in a biohazard box in the soiled utility room. The soiled utility room should be accessible to residents. Staff should ensure the soiled utility room is locked behind them. 5. Review of Resident #43's medical record, showed diagnoses included paranoid schizophrenia and nicotine dependence. Review of the resident's Smoking Assessment, dated 9/17/21, showed the resident was safe to smoke with supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan, updated on 10/29/21, showed: -Focus: The resident enjoys smoking and has the potential for smoking related injuries such as burns to his/her skin and clothes. He/she has wet lungs (Acute respiratory distress syndrome (ARDS) is a medical condition in which the lungs are not working properly and oxygen blood levels are too low) frequently and has refused all smoking substitutes offered; -Goal: The resident will remain free from injury related to smoking through the next review; -Interventions: Resident is a supervised smoker and will only smoke in the designated areas on the unit. Instruct him/her about the policy on smoking. Observe clothing and skin for signs of cigarette burns and notify charge nurse immediately if it is suspected that the resident violated the facility smoking policy. Review of the resident's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Moderate cognitive impairment; -Exhibited delusions, verbal behaviors and rejection of care one to three days per week; -Required limited assistance of one staff for locomotion on the unit. Review of the resident's medical electronic record, last reviewed on 1/25/22 at approximately 1:00 P.M., showed the Smoking Assessment 39 days overdue-due 12/17/21. During an interview on 1/25/22 at 1:50 P.M., the administrator and DON said smoking assessments should be done upon admission, annually and quarterly. The administrator provided a Smoking Assessment for the resident with a handwritten date of 1/13/22. MO00195525 37681 40290

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44948 Based on observation, interview, and record review the facility failed to adequately support the nutritional status of 1 of 24 sampled residents by not following RD (Registered Dietician) recommendations and physician orders (Resident #115). The facility census was 121. Review of Resident #115's quarterly Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, updated 12/20/21, showed: -Moderate cognitive impairment. -Resident dependent on staff for all Activities of Daily Living (ADLs). -Diagnoses included dementia, hemiplegia (the functional use of the upper limbs only), seizure disorder, anxiety, depression, and psychotic disorder. Review of the resient's care plan, updated on 12/20/21 and in use during the survey, showed: -Focus: Resident prefers to eat meals in bed, has risk of aspiration while eating in bed, has history of poor appetite, will drink supplements; -Goals: Resident will get out of bed for meals and be free of aspiration through next review; -Interventions: Diet changed to puree, encourage resident to get out of bed for meals, Ensure (a liquid calorie and protein supplement) twice per day, nectar thickened liquids, monitor for meal intake, Supercereal (a porridge-like substance with extra calories and protein) at breakfast, 90ml (milliliters) ReadyCare 2.0 (nutritional supplement) three times per day, house shake with all meals. Review of the resident's medical record, showed: -A weight loss of 15.19% over the last 6 months; -A weight loss of 5.34% over the last month; -A progress note on 12/20/21 from the RD stated the resident should receive supercereal with each breakfast meal, Ensure shakes, a daily multivitamin, and double portions at all meals. Review of the January 2022 physician order sheet, showed the following nutritional orders: -An order from 2/19/21 and revised on 10/24/21 for a regular diet, pureed texture, and nectar consistency liquids; -An order from 2/19/21 and revised on 10/24/21 for supercereal to be served at breakfast meals; -An order from 6/27/21 for ReadyCare 2.0 (high calorie, high protein nutritional drink) to be given three times per day; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff failed to obtain orders for the RD's receommendation of Ensure shakes, a daily multivitamin, and double portions at all meals. Review of the resident's medication administration (MAR), showed: -ReadyCare 2.0 not administered 93 out of 93 possible opportunities in November, 2021; -ReadyCare 2.0 not administered 93 out of 93 possible opportunities in December 2021; -ReadyCare 2.0 not administered 75 out of 75 possible opportunities up to the last date of the on-site survey in January, 2022. Observation of the lunch meal on 1/20/22 at 12:56 P.M., showed the resident lay in bed being fed by nursing staff. The resident's meal was pureed, but did not include double portions. No supercereal was observed on the resident's meal tray. No meal supplements were given to the resident during this meal time and less than half of the meal was consumed. Observation of the breakfast meal on 1/24/22 at 8:23 A.M., showed the resident lay in bed being fed by nursing staff. The resident's meal consisted of pureed eggs, pureed sausage, and thickened juice. No supercereal or meal supplements were given to the resident during this meal time. During an interview on 1/25/22 at 1:29 P.M. the Director of Nursing (DON) and administrator stated they would expect residents to receive ordered supplements as prescribed. MARs should accurately reflect medications and supplements given to residents, and staff should complete the MAR once a medication or supplement is given to a resident. During an interview on 1/28/22 at 10:54 A.M the facility's RD said she visits the facility once or twice a month. During those visits she sees residents who are on tube feedings (therapy where a feeding tube supplies nutrients to people who cannot get enough nutrition through eating), have significant weight loss, or are new admissions. Dietician recommendations are communicated through a standard health technologies report sent to the administrator, and dietary manager. Currently the dietician is unable to view resident meal tickets, so she is unable to verify what residents in her care are receiving for each meal daily. The RD stated she would expect her recommendations to staff to be followed in order to promote the nutritional health of residents. If recommendations are not followed, residents could experience further weight loss and malnutrition. At her last visit, she recommended double portions at meals, Supercereal with breakfast, a daily multivitamin, Ensure shakes, and ReadyCare 2.0 three times daily. The Registered Dietician stated she did not know her recommendations were not being followed and reported it was very disheartening to hear that.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 29948 Based on interview and record review, the facility failed to ensure one resident of 24 sampled residents (Resident #55), diagnosed as having dementia with behavioral disturbance and exhibiting symptoms/behaviors which contributed to a pattern of falls with injury, received the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being by failing to fully inform his/her psychiatric nurse practitioner (NP) of behaviors which included the following: standing unassisted from his/her wheelchair and bed, wandering throughout the secured unit at night with an unsteady gait, screaming and attempting to enter other residents' rooms. The facility failed to obtain a urine specimen as ordered in a timely manner, failed to ascertain urinalysis results and report them to the NP. Additionally, the facility failed to update the Interdisciplinary team (IDT) of the resident's behaviors, develop and implement a plan of care to address his/her needs. The census was 121. Review of the facility's policy titled, Fall Evaluation and Prevention, revised 8/2020, showed direction for the facility to evaluate residents for fall risk and develop interventions for prevention. The goal was to prevent falls if possible and avoid injury related to falls. A fall was defined as a sudden, uncontrolled, unintentional downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. The policy defined an unwitnessed fall as having occurred when a resident was found on the floor and neither the resident nor anyone else knew how he/she got there. Intrinsic risk factors for falls included changes which were part of normal aging as well as certain acute or chronic conditions and certain classes of medications. Examples of common intrinsic risk factors included confusion, depression, gait and balance disorders, vision and hearing impairments, muscular weakness (particularly of the lower extremities). Review of Resident #55's undated clinical physician's orders, showed the following: -4/1/21, Seroquel (antipsychotic which treats schizophrenia, bipolar disorder and depression) 25 milligrams (mg) daily; -6/4/21, Melatonin (used for short-term treatment of insomnia) tablet 3 mg at bedtime; -6/27/21 Seroquel, 50 mg daily. Review of the resident's social service note, dated 9/24/21 at 2:30 P.M., showed the resident enjoyed talking with his/her peers in the locked unit as well as playing bingo, making art, listening to music and watching movies. Review of the resident's progress notes, showed the following: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/20/21 at 12:20 A.M. (late entry for 11:45 P.M.) the resident slipped onto his/her buttocks from the couch. The resident was unable to describe what happened. Range of motion (ROM) performed to upper and lower extremities with no complaint of pain. The resident was in his/her bare feet. Staff applied non-skid socks. Staff educated the resident that he/she must wear socks or shoes, when getting up. The resident said, you're not going to be talking to me like a dog. Staff assisted him/her to the bathroom and to bed; -10/21/21 at 9:45 A.M., staff noted the resident guarding his/her right arm. The resident verbalized having experienced pain to that limb, since the fall on the previous day. Staff notified the resident's NP and received an order for an x-ray to rule out a fracture. At 11:39 A.M., the charge nurse noted the resident's radiology report showed a right humerus (the bone of the upper arm/forelimb, forming joints at the shoulder and elbow) fracture. The NP was in-house, reviewed the report and issued an order to send the resident to the hospital. At 8:00 P.M., the charge nurse received report on the resident from the hospital nurse. The resident was diagnosed with a displaced fracture (gap formed where the bone was broken) to the right humeral neck (any break in the bone extending from the shoulder to the elbow) and was to wear a sling until it healed; -10/31/21 at 9:29 P.M., the resident was ambulating with a slightly unsteady gait and had to be redirected/assisted back to his/her chair. The resident did not wear a sling to the arm or keep non-skid socks on for any period of time; -11/1/21 at 1:57 P.M., the resident was ambulating with a slow, unsteady gait instead of using his/her wheelchair. Staff reseated the resident several times. At 11:10 P.M., staff noted that the resident continued to guard his/her right arm, but also continued to remove the sling. Staff was not able to educate the resident due to his/her cognition. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/3/21, showed the following: -Severe cognitive impairment; -Psychosis: delusions; -Diagnoses including dementia, manic depression, repeated falls, fractures and other multiple trauma, fracture of upper end of right humerus and closed fracture; -Verbal behavioral symptoms directed at others occurred 1-3 days; -Wandering occurred four to six days, but less than daily; -Wheelchair mobility; -Required set up and supervision of locomotion on unit; -Required extensive assistance of one with transfers, ambulation, locomotion off unit, dressing, toilet use and personal hygiene. Further review of the resident's progress notes, showed the following: (continued on next page)

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	265585	A. Building B. Wing	01/25/2022

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/4/21 at 10:00 P.M., staff found the resident sitting on the floor in his/her room. When asked how he/she got there, the resident said he/she slipped and fell . Vital signs 126/73 (blood pressure normal range: 90/60 mm/Hg (millimeters of mercury) to 120/80 mm/Hg), 75 (pulse normal range: 60-100 beats per minute), 18 (respiration normal range: 12 - 18 breaths per minute), 98.3 (temperature normal range: 97.8 - 99.1 degrees Fahrenheit), 91% (oxygen saturation normal range: 94% to 99%). Neurochecks within normal limits; -11/5/21 at 4:24 A.M., staff administered pain medication, due to the resident's non-compliance with wearing the sling to his/her right arm. When staff educated the resident on the importance of the sling, the resident said, I don't need it; -11/11/21 at 12:06 A.M., the resident was up and down. Staff could not redirect the resident, who became agitated, combative and yelled. He/she refused to keep his/her arm sling in place; -11/13/21 at 5:22 A.M., the resident's gait was unsteady and he/she refused refusing to wear sling for his/her fractured right arm. The resident needed constant reminders to utilize his/her wheelchair for mobility. He/she was awake all night. Staff assisted the resident to bed several times and he/she would be back up wandering around the unit. The resident became combative, when staff applied skid-free socks; -11/14/21 at 10:48 P.M., the resident refused to wear his/her sling and needed constant reminders to stay out of other residents' rooms. At 2:52 A.M., the resident's gait was unsteady. He/she refused to wear his/her sling, needed constant reminders to use his/her wheelchair and was non-compliant with care; -11/15/21 at 3:55 A.M., the resident was awake most of the night, up in his/her room and the hallway. He/she continued to refuse to wear his/her sling. Staff noted increased anxiety and agitation in him/her upon redirection. Staff assisted the resident to bed several times. Further review of the resident's undated clinical physician's orders, showed an order dated 11/22/21, for Mirtazapine (antidepressant) 7.5 milligrams daily. Further review of the resident's progress notes, showed the following: -11/24/21 at 3:40 P.M., the resident continued to transfer him/herself to wheelchair without assistance, remove his/her arm sling and become agitated with education and redirection; -11/25/21 at 7:47 P.M., staff documented that the resident exhibited agitated behavior, was verbally aggressive and refused his/her meal. The resident said, you force feeding me. At 9:46 P.M., the resident was out of bed sitting on the roommate's bed, telling him/her to go to sleep and disturbing him/her. The roommate said, why don't you just go to bed? Staff assisted the resident back into bed and then eventually out of bed and into a wheelchair, due to the resident continuing to disturb the roommate; -11/27/21 at 10:45 A.M., staff observed the resident on the floor of the chapel and noted an abrasion to the right forehead and eye. When asked what happened, the resident said, I got up to walk and fell . Then I was crawling. His/her vital signs were as follows: 100/60, pulse 69, respirations 17, oxygen saturation 96%; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/28/21 5:49 A.M., the resident was up all night on one-on-one supervision with the nurse. The resident kept trying to ambulate without assistance, was difficult to redirect and became agitated. Staff gave the resident cookies and water. He/she attempted to go down the hallway with a peer of the opposite sex. At 9:56 A.M., staff witnessed the resident slide down out of his/her wheelchair, sit on the floor, lie flat on his/her back, then begin crawling and yelling for help. Staff assisted the resident back to his/her wheelchair and placed him/her in front of the nurse's station. The resident continued yelling help and attempting to get out of the wheelchair; -No Activities notes for November 2021. -12/1/21 at 9:31 P.M., the resident required heavy assistance from staff, to keep him/her safe, as the resident was a fall risk and continued to get up from his/her wheelchair and bed without assistance. Review of the resident's physician patient visit note, dated 12/2/21, showed staff reported a concern about the resident due to poor intake, increased confusion and borderline low blood pressure. The resident had advanced dementia with behavioral disturbance and was no longer on psychiatric medications, except for a low dose of Seroquel per the psychiatric physician. Further review of the resident's undated clinical physician's orders, showed the following: -12/2/21, change in primary care physician; -12/2/21, Urinalysis with culture; -12/6/21, change in psychiatrist provider. Further review of the resident's progress notes, showed: -12/3/21 at 7:57 P.M., the resident had to be redirected throughout the shift. He/she continued to attempt to stand up out of his/her wheelchair or slide down. Staff had to monitor the resident one-on-one during shift; -12/4/21 at 9:24 P.M., the resident remained on one-on-one monitoring after his/her fall. Redirection was difficult and often unsuccessful; -12/5/21 at 11:30 P.M., the resident fell in his/her room. Staff completed an assessment and ROM. The resident was non-compliant and confused. Review of the resident's fall scale, dated 12/9/21, showed a score of 65.0 which indicated a high risk for falling. Further review of the resident's progress notes, showed the following: -12/20/21 at 2:05 P.M., the urine sample was collected. FedEx picked it up; -12/20/21 at 10:19 P.M., showed the resident was on incident follow up (IFU) for a swollen top lip. He/she could not recall how or when the incident occurred; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/22/21 at 3:21 P.M., the resident was alert and oriented times two to three. He/she had experienced a decline in both gait and cognition. The resident used a wheelchair due to an unsteady gait. He/she tended to wake at night, wander down the hall and yell for no reason; -No further notes regarding the urinalysis; -No Activity notes for December, 2021. Review of the psychiatric encounter note, dated 12/22/21, showed establishment with his/her new psychiatric provider. Staff reported the resident was falling frequently and more confused recently. Staff reported the resident slept well and had a fair appetite. No agitated or aggressive behavior reported by staff. The clinical opinion of Psychiatric NP S was that the resident was not at baseline, but she was awaiting results of the urinalysis before considering changes to the resident's psychotropic medication. Further review of the resident's undated clinical physician's orders, showed an order dated 1/5/22, for frequent monitoring every shift for safety. During an interview on 2/1/22 at 12:03 P.M., Assistant Director of Nursing (ADON) U said the order for frequent monitoring meant exactly what it said; that nursing staff was to frequently check on the resident (there was no specific number of times during a shift), due to the fact that the resident constantly got up and was hard to redirect. The resident was not on one-to-one supervision. So, staff was expected to keep a set of eyes on the resident. Further review of the resident's progress notes, showed the following: -1/9/22 at 3:01 A.M., the resident woke up yelling, It's time to eat or I'm busting your head. Staff served the resident two cups of yogurt. The resident continued to fuss, but not speaking of fighting. 11:08 P.M., the resident was sitting in the TV room. The certified nurse aide (CNA) discovered the resident had a hematoma to the forehead. The resident said he/she was not in pain and did not know what happened. The nurse applied ice to the resident's forehead, notified the resident's physician and power of attorney; -1/10/22 at 7:35 A.M., at 10:45 A.M., staff found the resident in bed resting with a towel around his/her head with some swelling to the left side of the head. No discoloration/bruising noted. The resident responded to verbal and touch stimuli. His/her eyes reacted to light. Passive ROM was tolerated. At 8:28 A.M., staff documented the following vital signs: 97.7, 18, 76, 130/74. The nurse applied a cool compress. At 9:16 A.M., the nurse documented notification via the physician's exchange and ordered a skull series; -1/11/22 at 3:20 A.M., the resident had some swelling down the left side of his/her forehead; -1/12/22 at 10:55 P.M., the resident continued to get up out of his/her wheelchair, was constantly having to be redirected and asked to sit in his/her wheelchair. The resident had bruising to the left side of the face and would not stay in bed; (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/18/22 at 3:56 A.M., the resident was pacing up and down the hallway all night, yelling off and on. The resident continued to have some swelling to the left side of the forehead and both eyes. He/she remained difficult to redirect, pulling at medication carts and other residents' doors; -No Activity notes through 1/18/22. Review of the resident's undated care plan, showed the following: -The resident has a diagnosis of dementia, has a history of resistance to care, as well as a history of agitated, delusional, hyperactive behaviors; -If the resident resists with activities of daily living (ADLs), reassure the resident, leave and return five to ten minutes later and try again; -The resident has a diagnosis of insomnia, has a history of being up all night and sleeps during the day; -Encourage the resident to be out of bed during the day, monitor sleep patterns, inform the physician if melatonin is not effective; -Redirect negative moods/behaviors; -The resident is not cognitively stable and is not capable of using a call light for assistance; -Poor safety awareness and decreased comprehension; -The resident has dementia and cannot retain education; -Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated; -ADL self-care performance deficit related to confusion and dementia; -Unsteady gait, history of falls and gait disturbance; -1/22/21, the resident slid out of his/her roommate's bed, hit his/her head on the dresser and incurred a quarter-sized hematoma to the left forehead. During an interview on 2/1/22 at 2:50 P.M., ADON U said that nursing had collected a sample for the urinalysis and sent it out. However, the lab was saying that they did not have or process the sample. Consequently, the facility never received any results. ADON U discovered this on 2/1/22, when asked about the results. It is the responsibility of the two ADONs to follow up on ordered labs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/22 at 1:23 P.M., CNA T said he/she worked on the resident's unit from 11:00 P. M. until 7:00 A.M. On 1/18/22, CNA T was still in orientation and it was his/her first night on the floor. When he/she arrived for the night shift, the resident was pacing from one end of the unit to the other all night. He/she was the only resident up and would not go to sleep. Whenever CNA T put non-skid socks on the resident's feet, the resident removed them. The resident understood verbal redirection, but it only seemed to irritate him/her. He/she would say, you don't know what you're talking about. Two minutes later, the resident would be back up ambulating with a gait which was steady, until the resident appeared to grow tired. At that point, the resident's gait looked wobbly; like he/she might fall. CNA T felt compelled to follow the resident, which further irritated him/her. The resident said, you ain't got to follow me. The resident attempted to enter other residents' rooms. That appeared to be due to the resident not knowing his/her room number. The resident did not fall asleep until 6:15 A.M. During an interview on 1/21/22 at 11:08 A.M., the social services director said the resident was currently on quarantine for COVID. He/she went into quarantine on 12/13/21. The resident could not understand why he/she could not go into certain areas of the COVID unit. However, it was the social services director's understanding that the resident was easily redirected and would be okay for a little while. Having consistent staff often helped with behavioral issues in residents with dementia. With new staff, that was often an issue. No one said anything to the social services director about the resident wandering around the unit all night and requiring constant redirection as well as one-on-one supervision, due to persistent self-transfers and ambulating on bare feet with an unsteady gait. During an interview on 1/27/22 at 12:07 P.M., the Medical Director said medical problems could cause mental status changes. He/she had gone to see the resident on 12/2/21, upon request of the facility and ordered labs, which included an urinalysis, in addition to prescribing tramadol for pain. However, the psychiatrist also needed to be notified of the resident's increased confusion and behavioral issues such as wandering and agitation. Both underlying problems with the resident's disease process and psychiatric issues could result in behaviors which contributed to falls. During an interview on 1/24/22 at 2:54 P.M., psychiatric NP S said on 12/22/21, he/she received a report from staff of behaviors and the resident not sleeping well. The resident's symptoms appeared to be related to dementia. Not wanting to be too aggressive with treatment, NP S was waiting on results from a urinalysis ordered by the primary care physician. He/she never got a call from nursing with the results. So, NP S assumed that there had not been a change or worsening in the resident's behavior. Although staff indicated the resident was exhibiting behaviors, they did not go into details. Consequently, NP S was unaware of the resident wandering around the unit all night and periodically yelling for no apparent reason, experiencing increased confusion, increased falls and non-compliance with redirection. If staff had informed NP S of those issues, then he/she would have adjusted the resident's medications. The resident yelling at night and/or attempting to enter other residents' rooms were behaviors which could easily upset other residents in the unit and posed a risk for them reacting with aggression. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/22 at 2:56 P.M., the Director of Nursing (DON) said the resident's behaviors were tied to dementia. His/her psychiatric NP had just looked at the resident's medications and saw that they were ineffective. Consequently, the psychiatric NP would perform a medication review, in order to prescribe doses or medication changes which would treat the resident's symptoms of wandering and insomnia. Due to the resident's dementia disease process, the IDT was going to consider obtaining hospice services, for the resident's decrease in intake and overall decline. Despite the fact that the resident ate snacks, he/she burned a lot of calories with all of his/her wandering. The DON expected staff to keep the psychiatric NP informed of new behavioral issues. The facility used a lot of agency staff, so nursing staff was to document behavioral issues on the 24 hour report (consisting of a note which triggered a 72 hour look back review of progress notes). The report was reviewed and discussed by the IDT during daily clinical meetings. The team would subsequently decide whether or not to update the residents' care plans and what interventions should be implemented. Acute/temporary behavioral issues were not always added to the care plan. During an interview on 1/25/22 at 8:13 A.M., the administrator said when a resident with a diagnosis of dementia with an unsteady gait persisted with self-transfers, staff should try redirection and stay with him/her. If verbal redirection was unsuccessful, then they should walk with the resident and have him/her sit with them. The CNA should inform the nurse, who should assess the resident, contact the resident's physician and see if he/she wanted a lab like a urinalysis ordered. The nurse should also notify the resident's psychiatrist. Staff should update the resident's care plan, whenever a new pattern of behaviors emerged. Any nurse could update the care plan. The MDS Coordinator was ultimately responsible for ensuring the care plan was updated. The MDS Coordinator was not on duty during the night shift. However, during the IDT meetings, all department heads were notified of new resident concerns. All notifications made by staff should be documented in a resident's progress notes. If it was not written, then it was not performed. MO00194059 44948

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44948 Based on observation, interview and record review, the facility failed to appropriately store non-expired medications and equipment in two of three facility medication storage rooms and in one of five nurse treatment carts. Staff also failed to secure narcotic medication. The facility census was 121. Review of the facility's Storage of Medications policy, revised April 2007, showed: -Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers; -The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner; -The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed; -Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications; -Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications; -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others; -Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly; -Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. 1. Observation of the first floor medication room on 1/19/22 at 12:10 P.M., showed expired medications included: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Three boxes of [NAME] Real Time Control Solution (a liquid used to calibrate glucose (blood sugar) monitors to produce accurate results) expired as of November 2021.; -Three bottles of Hormel Thick and Easy cranberry juice expired as of 1/7/21. -One box of Urinox-10 urinalysis test strips (used to determine the presence of bacteria in urine samples) expired as of 9/30/21.; -One tube of ConvaTec stomahesive ostomy (an artificial opening in the abdomen) wound appliance expired as of August 2021; -One box of Nexodyn ointment (antimicrobial wound care solution) expired as of 5/14/20.; -Two Dynarex suction tubing extensions (used for suctioning the airway) expired as of September 2019; -One Medikmark non sterile spill clean-up kit (used for cleaning up hazardous substances) expired as of September 2017; -Two Stradis non sterile spill clean-up kit expired as of 1/31/20. 2. Observation of a second floor nurse's cart on 1/19/22 at 12:44 P.M., showed one bottle of Hormel thickened cranberry juice expired as of 1/7/21 and two tubes of Dermacerin (moisturizing cream) expired as of November, 2021. 3. Observation of the second floor medication room on 1/19/22 at 1:03 P.M., showed expired medications included: -Two bottles of Ferrous Sulfate (an iron supplement) expired as of 1/7/21; -Two boxes of [NAME] Real Time glucose control solution expired as of November of 2021. Further observation of the second floor medication room on 1/19/22 at 1:03 P.M., showed no lock on the medication room refrigerator door that contained stock narcotic medications. 4. Observation of a third floor treatment cart on 1/19/22 at 1:26 P.M., showed one bottle of Nexodyn antimicrobial wound care solution expired as of 5/14/20. 5. During an interview on 1/25/22 at 1:29 P.M. the Director of Nursing and administrator said they would expect nursing staff and certified medication technicians to dispose of expired medications. Medications that are expired should not be used for resident treatments. Night shift nursing staff are responsible for calibrating glucometers (a machine that calculates blood sugar levels) each night, and they would expect staff to verify expiration dates on glucose control solutions before using them to calibrate a glucometer. Narcotics kept in a medication room refrigerator should be kept behind two locks.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37681 Based on observation and interview, the facility failed to ensure meal service tray temperatures were maintained to at least 120 degrees Fahrenheit (F). Five out of six residents attending the Resident Council meeting complained about the food temperatures. The census was 121. Observation of the lunch meal service on 1/24/22 at 11:53 A.M., showed the prepared food on the warm server in the kitchen. Styrofoam plates sat on top of the server. Three wheeled carts held beverages. Dietary Aide (DA) D began placing food onto the Styrofoam plates. DA E took the plates and placed them onto the wheeled cart, with the beverages, to deliver to the units. The cart did not have any components to keep the meals warm while in transport. Further observation on 1/24/22, showed: -At 1:00 P.M., the cart which held the lunch trays was delivered to the second floor. The food was served in divided Styrofoam plates. A resident's tray was taken from the cart. The meal consisted of a beef patty, rice and vegetables. The beef patty reached a temperature of 115.5 degrees, using a digital thermometer; -At 1:25 P.M., the cart which held lunch was delivered to the third floor. The food was served in divided Styrofoam plates. A resident's tray was taken from the cart. The meal consisted of a beef patty, potatoes and mixed vegetables. The mixed vegetables reached a temperature of 98.4 degrees, using a digital thermometer. During a group interview on 1/20/22 at 2:00 P.M., five out of six residents said food was not hot enough and was served cold. The residents would prefer their food to be served hot. During an interview on 1/25/22 at 7:14 A.M., the Dietary Manager said she was aware of residents' complaints of cold food. When she first came to the facility, there were two portable steam tables, but they were no longer operable. She did not want staff to place hot food on a cold steam table because the plugs did not work. She requested a five well steam table. She also requested plate warmers, domes to cover the plates and a covered delivery cart to keep food warm during transport. She also in-serviced dietary staff on serving food at the appropriate temperatures. During an interview on 1/25/22 at 11:51 A.M., the administrator and Director of Nursing (DON) said food should be served hot.

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	265585	A. Building B. Wing	01/25/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37681 Based on observation, interview and record review, the facility failed to complete an inspection of bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four of 24 sampled residents to reduce the risks of accidents (Residents #93, #112, #8, and #45). The facility identified 27 residents who utilized bed rails. Of the 27 residents, four were sampled and problems were identified with all four. The census was 121. Review of the facility's Bed Rail Policy, dated 7/20/20, showed: -Preface: It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach will be used to achieve sustainable quality outcomes, including regular bed maintenances and individual bed rail evaluations. In response to the requirement of providing for a safe, clean, comfortable and homelike environment, the facility's regular maintenance program will include regular inspections of all bed systems (e.g. rails, frames, and mattresses and operational components) to ensure they are clean, comfortable and safe; -The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. The facility's priority is to ensure safe and appropriate bed rail use. 1. Review of Resident #93's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff0, dated 12/13/21, showed: -admitted on [DATE]; -Exhibited moderate cognitive impairment; -Required extensive assistance of two staff for bed mobility; -Required total dependence of two staff for transfers; -Diagnoses included cancer, high blood pressure and stroke; -Bed Rails used daily. Review of the resident's Side Rail Assessment, dated 12/15/21, showed: -Bilateral quarter side rails used; -No inspection of bed frames, mattresses and bed rails. Observation on 1/21/22 at 7:31 A.M., showed the resident lay in bed on his/her back with quarter length bed rails raised on both sides of the bed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 1/24/22 at 9:00 A.M., showed the resident lay in bed on his/her back with quarter length bed rails raised on both sides of the bed. The resident grabbed both bed rails and began to shake the rails. 2. Review of Resident #112's Side Rail Assessment, dated 12/13/21, showed: -Bilateral quarter side rails used; -No inspection of bed frames, mattresses and bed rails. Review of the resident's admission MDS, dated [DATE], showed: -admitted on [DATE]; -Severe cognitive impairment; -Required total dependence of two staff for bed mobility and transfers; -Diagnoses included diabetes and seizures; -Bed rails used daily. Observation on 1/21/22 at 7:30 A.M. and 1/24/22 at 9:00 A.M., showed the resident lay in bed on his/her back with quarter length bed rails raised on both sides. 3. Review of Resident #8's quarterly MDS, dated [DATE], showed: -admitted [DATE]; -Moderate cognitive impairment; -Total dependence of two (+) person physical assist required for bed mobility, transfers, locomotion and toilet use; -Upper extremity impaired on one side; -Diagnoses included end stage renal disease (ESRD, kidney disease), high blood pressure, seizures, anxiety, depression, bipolar disorder, schizophrenia, insomnia, restlessness and agitation and repeated falls. Review of the resident's quarterly side rail assessment, dated 1/12/22, showed the resident determined to benefit from bilateral quarter-length side rails. The assessment did not include an assessment for entrapment zones. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident is at risk for falls. Resident keeps bed in a high position and needs reminders to call for help; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Goals: Resident will be free of injury related to falls; -Interventions included two quarter-length side rails to aide in bed mobility and repositioning. Observation on 1/18/22 at 1:01 P.M., showed the resident in bed with a quarter-length side rail raised on the left side at the middle of the mattress. Observation on 1/19/22 at 12:54 P.M., showed the resident in bed with a quarter-length side rail raised on the left side at the middle of the mattress. During an interview, the resident said he/she used the side rail to reposition him/herself in bed. Observations on 1/21/22 at 7:23 A.M. and 1/24/22 at 9:08 A.M., showed the resident in bed with a quarter-length side rail raised on the left side at the middle of the mattress. 4. Review of Resident 45's annual MDS, dated [DATE], showed: -admitted [DATE]; -Severe cognitive impairment; -No behaviors exhibited; -Total dependence of two (+) person physical assist required for bed mobility, transfers, dressing, toilet use and personal hygiene; -Upper extremity impaired on one side; -Lower extremities impaired on both sides; -Diagnoses included traumatic brain injury, deep venous thrombosis (DVT, blot clot formed in a deep vein), diabetes, aphasia (impairment of expressing and understanding language), seizures, dementia, quadriplegia (paralysis affecting all four limbs) and osteomyelitis (bone infection). Review of the resident's quarterly side rail assessment, dated 11/10/21, showed the resident assessed for bilateral quarter-length side rails. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident requires total care with activities of daily living due to diagnosis of quadriplegia, has history of resistance, aggressive behaviors at times; -Goals: Staff will anticipate resident needs as needed; -Interventions included two quarter-length side rails for positioning. Observation on 1/18/22 at 12:10 P.M., showed the resident in bed with quarter-length side rails on both sides of the bed, at the middle of the mattress. During an interview, the resident was unable to say if he/she used the side rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 1/25/22 at 8:44 A.M., the Maintenance Director said he was not aware of the need to do routine inspections of bed rails and had not completed them. 6. During an interview on 1/25/22 at 11:44 A.M., the administrator and Director of Nursing said the Side Rail Assessments were completed, but maintenance had not completed an inspection of bed frames, mattresses and bed rails to reduce the risk of accidents. 40290