

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2024
NAME OF PROVIDER OR SUPPLIER Hillside Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1265 McLaran Avenue Saint Louis, MO 63147	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35394</p> <p>Based on observation, interview and record review, the facility failed to ensure all residents were treated in a manner to maintain dignity and respect for one sampled resident (Resident #5) after staff failed to close the door and pull the privacy curtain before providing incontinence care. The sample size was eight. The census was 145.</p> <p>Review of the resident bill of rights, showed:</p> <ul style="list-style-type: none"> -Right to privacy: Residents have the right to privacy in their treatment and care, and to have their personal affairs kept confidential; -Right to dignity: Residents have the right to be treated with dignity and respect at all times. <p>Review of Resident #5's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/9/24, showed:</p> <ul style="list-style-type: none"> -Cognitively intact; -Diagnoses included deep venous thrombosis (blood clots), neurogenic bladder (urinary problems due to disease or injury to the central nervous system), septicemia (blood poisoning), seizure disorder, and anxiety; -Required substantial/maximum assistance with showers/bathe self and personal hygiene. <p>Review of the resident's care plan, in use during survey, showed:</p> <ul style="list-style-type: none"> -Focus: Resident has an Activity of Daily Living (ADL) care performance deficit; -Goals: Resident will maintain current level of function in ADLs; -Interventions: Provide sponge bath when a full bath or shower cannot be tolerated; -Resident is totally dependent on one staff to provide bath/shower; -Resident is bedfast all or most of the time; <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident is totally dependent on one staff for dressing;</p> <p>-Resident requires extensive assistance for personal hygiene/oral care;</p> <p>-Resident is not toileted.</p> <p>Observation on 11/4/24 at 1:45 P.M., showed the resident in his/her bed, receiving a bed bath from staff. The resident was in a room with three other roommates. Only one roommate was present at the time. The roommate was across the room from Resident #5. The resident's bed was located on the further side of the entrance. The resident's roommate to the right of him/her was not in bed and the privacy curtain between the two beds was not pulled and the door was not closed. The resident was visible from the hall as staff provided the bed bath. The resident lay naked in bed as staff provided care. No privacy curtain was available to provide privacy in front of the resident's bed for privacy between him/her and roommate across the room. Staff carried incontinence supplies to the trash can in the hall and reentered the resident's room again without closing the door. Residents and staff walked by the room with the door open as the resident lay exposed to the hallway.</p> <p>During an interview on 11/5/24 at 1:42 P.M., the resident said he/she wished staff would close the door during care. He/She was not bothered about the privacy curtain not pulled because his/her roommates are the same gender. They do not close the door when his/her roommate is getting dressed either. The resident pointed out that there was no privacy curtain between the roommate on the other side of the room; however, there was a privacy curtain between him/her and the roommate next to him/her.</p> <p>Observation and interview on 11/5/24 at 1:50 P.M., showed the Assistant Director of Nursing (ADON) walked down the hall and was asked if it was appropriate for staff to leave the door open while a resident received incontinence care. The ADON saw the open door and said it was not appropriate. The staff inside the resident's room shut the door at that time. The ADON said she would expect the privacy curtain to be pulled and the door closed for privacy.</p> <p>During an interview on 11/5/24 at 2:00 P.M., the Director of Nursing (DON) and Administrator said personal care should be provided in privacy by pulling the curtain and closing the door. It is not acceptable to provide personal care with the curtain and door open. The incident has already been addressed with the staff member and they have started educating all nursing staff on providing resident privacy during all cares.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable homelike environment for two of three dining rooms in use by residents and several common areas. The 300 main dining room had leaks, broken chairs, trash bags stored on the floor, and soiled curtains. The 200 main dining room had a leak. The 200 main day room with water leaks on the carpet. The 200 hall had cracks in the floor. In addition, the 100 hall had a Personal Protective Equipment (PPE) container in use that was soiled. The facility census was 145.</p> <p>1. Observation of 300 Main dining room, showed:</p> <p>-On 11/4/24 at 10:53 A.M., large brown stains covered the lower half of the curtains that hung up in the windows. There was a wet spot located on the floor and a yellow substance underneath the curtains;</p> <p>-On 11/4/24 at 11:30 A.M., six chairs with torn or detached seats. One resident sat on the edge of a chair that had a large tear visible in the center of the seat. During an attempted interview at this time, the resident was unable to explain why he/she sat on edge of the seat. He/She then scooted over some but attempted to avoid the large tear in the middle of the seat. At 12:32 P.M., staff served the resident his/her meal;</p> <p>-At 12:32 P.M., a trash bag sat directly on the floor with Styrofoam cups, napkins, and other trash inside the bag. Residents placed their trash in the bag, on the floor. No trash can visible in the dining room for resident or staff use;</p> <p>-On 11/5/24 at 10:14 A.M., the dining area was empty and contained approximately 22 chairs total. 11 of the chairs had torn seats and/or the seat was loose and nearly detached from the chair.</p> <p>2. Observation of the 200 Main dining room on 11/4/24 at 10:43 A.M., showed water leaked onto the floor against the back wall and underneath the windows. A wet floor sign was on the floor. Several soaked sheets and towels that absorbed the water lay on the floor. The leak started at the right side of the back wall and extended to the other side of the back wall, approximately 22 feet.</p> <p>During an interview on 11/4/24 at 10:43 A.M., two residents sat at a table with water under their feet and said this is not the first time there has been water on the floor. The staff will sometimes throw towels or covers down to soak up the water, but most times they do nothing. They do not even put up wet floor signs. Both residents said they were afraid they were going to fall on the wet floor.</p> <p>During an interview on 11/4/24 at 10:50 A.M., Certified Nurse Aide (CNA) A said the floor was wet this morning and he/she put towels down and made sure none of the residents were sitting nearby.</p> <p>3. Observation of the 200 Main day room on 11/4/24, showed:</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-At 10:56 A.M., six residents sat in the day room. Four of the residents sat in chairs and two sat in wheelchairs. The carpeting in front of the windows was wet. All residents sat in the wet area. One resident did not have on shoes, only socks. His/her socks sat on the wet carpeting and appeared wet.</p> <p>-At 11:00 A.M., wet carpet on the back, right corner of the room. The wet spot measured approximately 3 feet by 5 feet. Water leaked onto the floor against the back wall, underneath the windows. The carpet was wet from one side of the wall to the other side, approximately 12 feet. Track marks from the wheels of residents' wheelchairs were visible after residents propelled on the wet carpet.</p> <p>During an interview on 11/4/24 at 11:10 A.M., Resident #3 said the floor in the day room was wet and his/her socks were wet from walking in the day room. He/she was walking around and standing by the door because his/her socks were wet and he/she did not want to slip on the floor in the hall.</p> <p>Observation and interview on 11/4/24 at 11:12 A.M., showed CNA A in the hall charting and overheard the conversation with Resident #3. CNA A came over and asked if the resident's feet were wet. He/She assisted Resident #3 down the hall to put dry socks on him/her. As they walked down the hall, Resident #3 left wet footprints on the hard floor.</p> <p>4. Observation on 11/4/24 at 11:04 A.M., showed large cracks in the hardwood floor outside of rooms [ROOM NUMBERS]. The cracks measured approximately 20 feet, from rooms [ROOM NUMBERS] to the day room.</p> <p>5. Observation of 100 Main hall on 11/4/24 at 10:37 A.M. and 11/5/24 at 10:41 A.M., showed a three tier Personal Protective Equipment (PPE) container covered with dirt, dust and debris outside of rooms [ROOM NUMBERS].</p> <p>6. During an interview on 11/5/24 at 12:10 P.M., the Interim Regional Director of Maintenance said his first day was 11/4/24. He was not aware of the leaks in the dining rooms and day room until yesterday, so he did not know how long it was leaking. The building has bad seals on the windows and the roof. The caulk joints have fallen apart where the brick ledge starts. He can fit his thumb inside, so he was sure the leak had something to do with that. They have made calls to start repairs. When he came in, staff said they had water problems. He planned to do a thorough walk through. The chairs in the dining room will be replaced and curtains will be cleaned. The staff use TELs to report maintenance request, but nothing was reported regarding equipment. At 1:23 P.M., the Regional Director of Maintenance said they found eight chairs that were not being utilized and replaced them with the eight worst chairs on the floor. They only had eight chairs available.</p> <p>7. During an interview on 11/5/24 at 12:30 P.M., the prior Regional Director of Maintenance was contacted. He was not aware of the condition of the chairs in the 300 dining room, but said they can be replaced. The cracks in the floor were from a previous resident that resided on the hall. He/She took furniture and pushed it up and down the hallway so there are some decent sized gouges. They have bids to replace the flooring. The previous maintenance director that was here did not mention the issues. When there is an issue, they try to take care of it. They repaired the roof, so they did not know there was that much water. Staff did not report to maintenance that when it rained, there were leaks in the dining rooms and day room. The TELs system will tell staff what to do in case something needed to be repaired. They do not have a policy to address maintenance duties.</p> <p>(continued on next page)</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394</p> <p>Based on observation, interview and record review, the facility failed to ensure the handrails on each resident hall were properly maintained. This deficient practice had the potential to affect all residents on these halls. The facility census was 145.</p> <p>1. Observation of 100 South unit on 11/4/24 at 10:25 P.M., showed:</p> <ul style="list-style-type: none"> -Loose handrail outside of room [ROOM NUMBER]. The handrail was detached from the wall on one side; -Missing handrail between rooms [ROOM NUMBERS]; -Loose handrail outside of room [ROOM NUMBER] and 104. The handrail was missing screws; -Loose handrail outside room [ROOM NUMBER]; -Loose handrail outside of room [ROOM NUMBER]; -Loose handrail outside of the soiled utility room and nurse's station; -Loose handrail outside of the shower room; -Loose handrails on both left and right side outside the TV room. <p>2. Observation of 100 Main unit on 11/4/24 at 10:37 A.M., showed:</p> <ul style="list-style-type: none"> -Loose handrail outside of room [ROOM NUMBER]. Plaster on the wall also detached; -Loose handrail outside of shower room in front of nurse's station. <p>3. Observation of 200 Main unit on 11/4/24 at 10:43 A.M., showed:</p> <ul style="list-style-type: none"> -Missing end cap on the handrail outside of the stairwell and room [ROOM NUMBER]; -Missing end cap on the handrail in the hallway outside of the dining room. <p>4. Observation of 300 Main unit on 11/4/24 at 11:14 A.M., showed:</p> <ul style="list-style-type: none"> -Missing handrail between rooms [ROOM NUMBERS]; -Missing handrail between rooms [ROOM NUMBERS]; -Missing handrail outside of room [ROOM NUMBER]; -Loose handrail outside of room [ROOM NUMBER]; <p>(continued on next page)</p>

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. Observation of 300 South unit on 11/4/24 at 11:24 A.M., showed:</p> <ul style="list-style-type: none"> -Missing handrail outside of room [ROOM NUMBER]; -Missing handrail outside of the bathtub room and across from room [ROOM NUMBER]; -Missing end cap on the handrail covered in foil, outside of the shower room; -Loose handrail outside of room [ROOM NUMBER]; -Missing end cap on the handrail covered in foil, outside of room [ROOM NUMBER]; -Missing handrail outside of the dining room. <p>6. During an interview on 11/5/24 at 12:10 P.M., the Interim Regional Director of Maintenance said his first day was on 11/4/24. He was not aware of the loose/missing handrails but planned to do a thorough walk through. He has not assessed the equipment. They use the TELs system, but handrails were not reported. Handrails are a big priority.</p> <p>7. During an interview on 11/5/24 at 12:30 P.M., the Interim Regional Director contacted the previous maintenance director for additional information. The previous Regional maintenance director said there were a few handrails that were missing and the facility was in the process of replacing them. There are a large amount of handrails in the garage to replace the damaged and missing handrails. They come in custom sizes, but they have to put in a work order in the TELs system. The TELs system will notify staff what to do in case something needs to be fixed and they have monthly tasks as well. They do not have a policy.</p> <p>8. During an interview on 11/5/24 at 2:00 P.M., the Director of Nursing (DON) and Administrator said they were aware of missing handrails and are in the process of replacing them. They were not aware of the damaged handrails. A facility wide audit was done and they are looking in the garage for surplus handrails and will replace them.</p> <p>MO00244101</p> <p>MO00244299</p>		