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	02/06/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 27723 Based on observation, interview and record review, the facility failed to obtain physician orders and monitor a wound identified by staff for one resident (Resident #27). The census was 145. Review of the Wound Management Policy, revised 10/24/22, showed: -Purpose: provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers; -Definitions: Diabetic Neuropathic Ulcer: requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot; -Procedure: Assessment: -A licensed nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident; -Upon identification of a wound the licensed nurse will: -Measure the wound (length, width and depth); -Initiate a wound monitoring record sheet: -A wound monitoring record will be completed for each wound; -If the wound monitoring record is not used, documentation will be recorded within the medical record which may include nursing notes, treatment records or care plans; -An assessment of care needs for pressure ulcer and wound management will be made with emphasis on, but not limited to: -Identifying risk factors; -Treatment; -Mechanical offloading and pressure reducing devices; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
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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	-Reducing skin friction, sheer, and moisture; -Nutritional status; -Evaluating and modifying interventions for a resident with an existing PU/PI; -Wound Management: -The attending physician will be notified to advise on appropriate treatment promptly; -The licensed nurse will notify the responsible party of the presence of a pressure ulcer; -Dietary contact will be made for nutritional assessment; -Rehabilitation services will be contacted for appropriate devices or pressure redistributing devices; -A licensed nurse will develop a care plan for the resident based on recommendations of dietary, rehabilitation and the attending physician; -Per physician order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management; -The attending physician and interdisciplinary team (IDT) will be notified of: -New pressure ulcers or wounds; -Pressure ulcers or wounds that do not respond to treatment; -Pressure ulcers or wounds that worsen or increase in size; -Complaints of increased pain, discomfort or decrease in mobility by a resident; -Signs of ulcer sepsis, presence of exudates (drainage), odor or necrosis (black, firm tissue), if not already noted by the physician; -Residents refusing treatment; -Certified Nurse Aides (CNAs) will complete body checks on resident's shower days and report unusual findings to the licensed nurse; -Documentation: -New pressure ulcers or wounds will be documented on the 24 hour log and an incident report will be completed by the licensed nurse; -Wound documentation will occur at a minimum of weekly until the wound is healed, documentation will include: (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Location of wound; -Length, width, and depth measurements recorded in centimeters (cm); -Direction and length of tunneling (a channel or tunnel that forms beneath the surface of a wound, extending into deeper tissue) or undermining (a separation of the wound edges from the underlying tissues, creating a space or pocket beneath the wound surface; -Appearance of the wound base; -Drainage amount and characteristics including color, consistency and odor; -Appearance of wound edges; -Description of the peri-wound condition or evaluation of the skin adjacent to the wound; -Presence or absence of new epithelium at the wound rim; -Presence of pain; -IDT will document the discussions and recommendations for: -Pressure ulcers and wounds that do not respond to treatment; -Pressure ulcers and wounds that worsen or increase in size; -Complaints of increased pain, discomfort or decrease in mobility by a resident; -Signs of ulcer sepsis, presence on exudate, odor or necrosis; -Residents refusing treatment; -Licensed nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis; -Document notifications following a change in the resident's skin condition; -Update the resident's care plan as necessary. Review of Resident #27's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/21/25, showed the following: -Diagnoses of diabetes and peripheral vascular disease (PVD, poor circulation in the extremities), low blood pressure; -No cognitive impairment; -Required moderate assistance of staff for personal hygiene; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required maximum assistance of staff for toileting, showering and dressing; -No venous or arterial ulcers; -No foot ulcers. Review of the resident's care plan, updated 2/14/25, showed the following: -Focus: Resident has PVD; -Monitor, document, and report as needed any signs or symptoms of skin problems related to PVD: redness, edema, blistering, itching, burning, bruises, cuts, or other skin lesions. Review of the resident's shower sheet, dated 3/7/25, showed no documentation of any wounds to the right heel. Review of the facility's 24 hour shift report sheet, dated 3/8/25, showed a wound to the right heel. Review of the resident's progress notes, dated 3/8/25 through 3/19/25, showed no documentation regarding a wound to the right heel. Review of the resident's physician's order sheet (POS), dated March 2025, showed no treatment order for the resident's right heel. Review of the resident's treatment administration record (TAR), dated March 2025, showed no treatment order for the resident's right heel. Review of the resident's shower sheets, dated 3/10 and 3/13/25, showed no documentation regarding a wound to the right heel. The facility had no shower sheets for the week of 3/17 through 3/20/25. Observation on 3/20/25 at 10:55 A.M., showed the resident lay in bed. The Director of Nurses (DON), Assistant Director of Nurses (ADON) and the facility's Wound Care Company's Nurse Practitioner (NP) assessed the resident's skin and noted a wound on the back of the resident's right foot just above the heel. The Wound Care NP said the wound was a diabetic ulcer secondary to pressure that measured 0.6 centimeters (cm) by 0.6 cm by 0.3 cm depth, 90% granulation (new tissue) and 10% slough (soft dead tissue). During an interview on 3/20/25 at 12:02 P.M., CNA W said he/she was unaware of the wound on the resident's right heel. He/She hadn't taken care of the resident before and had assisted another aide giving him/her a shower. He/she could not remember the name of the aide who she assisted. During an interview on 3/20/25, at 1:26 PM., ADON W said he/she was unaware of the wound on the back of the resident's heel. No one reported it to him/her nor did he/she see it on the 24 hour sheet. Staff are to document any changes in the progress note which can be generated on a summary sheet daily. He/She expected staff to document any changes found in the progress note and obtain treatment orders. (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 3/20/25 at 11:10 A.M., the DON said when staff find a wound, she expected the nurse to call the physician, get a treatment order, notify the DON and the wound company. 44950

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 Based on observation, interview and record review, the facility failed to follow the facility's policy regarding wound care when staff failed to ensure continued wound care treatments following a hospitalization with an identified pressure injury (a localized area of skin damage that develops when prolonged pressure is applied to the body) to the tailbone (sacrum) upon discharge for one resident (Resident #14). The failure resulted in the worsening of the identified sacral wound and the development of two additional pressure injuries. Staff failed to ensure accurate documentation, notify the physician of worsening wounds since hospitalization and obtain wound care orders. In addition, staff failed to ensure timely wound dressing change to identified saturated dressings (Resident #16). The census was 145. Review of the Wound Management Policy, revised 10/24/22, showed: -Purpose: provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers; -Definitions: -Pressure ulcer: any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed; -Procedure: Assessment: -A licensed nurse will perform a skin assessment upon admission, readmission, weekly, and as needed for each resident; -Upon identification of a wound the licensed nurse will: -Measure the wound (length, width and depth); -Initiate a wound monitoring record sheet: -A wound monitoring record will be completed for each wound; -If the wound monitoring record is not used, documentation will be recorded within the medical record which may include nursing notes, treatment records or care plans; -An assessment of care needs for pressure ulcer and wound management will be made with emphasis on, but not limited to: -Identifying risk factors; -Treatment; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Mechanical offloading and pressure reducing devices; -Reducing skin friction, sheer, and moisture; -Nutritional status; -Evaluating and modifying interventions for a resident with an existing PU/PI; -Wound Management: -The attending physician will be notified to advise on appropriate treatment promptly; -The licensed nurse will notify the responsible party of the presence of a pressure ulcer; -Dietary contact will be made for nutritional assessment; -Rehabilitation services will be contacted for appropriate devices or pressure redistributing devices; -A licensed nurse will develop a care plan for the resident based on recommendations of dietary, rehabilitation and the attending physician; -Per physician order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management; -The attending physician and interdisciplinary team (IDT) will be notified of: -New pressure ulcers or wounds; -Pressure ulcers or wounds that do not respond to treatment; -Pressure ulcers or wounds that worsen or increase in size; -Complaints of increased pain, discomfort or decrease in mobility by a resident; -Signs of ulcer sepsis, presence of exudates (drainage), odor or necrosis (black, firm tissue), if not already noted by the physician; -Residents refusing treatment; -Certified Nurse Aides (CNAs) will complete body checks on resident's shower days and report unusual findings to the licensed nurse; -Documentation: -New pressure ulcers or wounds will be documented on the 24 hour log and an incident report will be completed by the licensed nurse; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound documentation will occur at a minimum of weekly until the wound is healed, documentation will include: -Location of wound; -Length, width, and depth measurements recorded in centimeters (cm); -Direction and length of tunneling (a channel or tunnel that forms beneath the surface of a wound, extending into deeper tissue) or undermining (a separation of the wound edges from the underlying tissues, creating a space or pocket beneath the wound surface; -Appearance of the wound base; -Drainage amount and characteristics including color, consistency and odor; -Appearance of wound edges; -Description of the peri-wound condition or evaluation of the skin adjacent to the wound; -Presence or absence of new epithelium at the wound rim; -Presence of pain; -IDT will document the discussions and recommendations for: -Pressure ulcers and wounds that do not respond to treatment; -Pressure ulcers and wounds that worsen or increase in size; -Complaints of increased pain, discomfort or decrease in mobility by a resident; -Signs of ulcer sepsis, presence on exudate, odor or necrosis; -Residents refusing treatment; -Licensed nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis; -Document notifications following a change in the resident's skin condition; -Update the resident's care plan as necessary. 1. Review of Resident #14's medical record, showed: -Original admission: 1/27/25; -Diagnoses included: quadriplegia (paralysis in all limbs), Parkinson's (a neurodegenerative disease causing muscle weakness and loss), diabetes, anxiety, muscle wasting, and reduced mobility; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Able to make needs and wants known. Review of the progress notes, showed: -On 2/3/25 at 11:26 P.M., a nurse note: the resident remained up in his/her wheelchair. Staff offered to assist to bed to encourage wound healing; -On 2/5/25 at 1:15 P.M., a nurse note: the resident said he/she was short of breath and complained of a sore throat and coughed thick, yellow mucus, complaint of minor chest pain. Vital signs: blood pressure 140/70 (normal, 120/80), temperature 101.3 degrees (normal range, 97.1-98.6 degrees Fahrenheit (F)), pulse 116 beats per minute (bpm) (normal range, 60-80 bpm) and oxygen saturation fluctuating between 87-90 percent (normal range, 90-100%). The physician notified and new orders to send to the emergency room for evaluation and treatment. Review of the February Treatment Administration Record (TAR), dated 2/1/25 through 2/28/25, showed: -An order, dated 2/6/25: enhanced barrier precautions related to wounds; -An order, dated 1/28/25: Triad Hydrophilic (used to create a moist wound environment, that promotes healing and debridement (removal of dead tissue) wound dressing paste. Apply to right buttock and left thigh twice a day for wound. Discontinued 2/7/25. Documented as completed twice a day, until discharged to the hospital on 2/6/25. Review of the hospital discharge summary, dated 2/12/25, showed: -admitted to the hospital: 2/5/25; -Diagnoses: Pneumonia and sepsis; -Wound dressing paste: apply one application topically twice a day to right buttock and left thigh wounds; -Wound care instructions: -Incontinent associated dermatitis (IAD, skin damage associated with incontinence) bilateral (both sides) buttocks; -Dressing status: open to air; -Site assessment: fragile, painful and pink; -Shape/pattern: irregular; -Peri-wound assessment: fragile, painful; -Interventions: cleansed, protective ointment; -Wound status: unchanged; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Non-staged description: partial thickness;. -Pressure injury to coccyx: -Dressing status: open to air; -Site assessment: Fragile, painful; -Shape/pattern: Irregular; -Peri-wound assessment: Fragile, painful; -Interventions: cleansed, protective ointment; -Pressure injury Stage: II (partial thickness skin loss, appearing as a shallow, open ulcer with a red or pink wound bed, or as an intact or open/ruptured blister); -Measurements: length 3 cm x width 4 cm; -Margins: Undefined edges; -Wound status: Unchanged;. -Medication list at discharge: -Hydrophilic cream (used to treat and prevent dry, rough and itchy skin): one application topically twice a day to the right buttock and left thigh wounds. -Nutrition orders: -Juven (high protein supplemental drink) twice a day, with breakfast and dinner. Review of the facility's admission assessment, dated 2/12/25, showed: -admitted from: hospital; -Skin assessment: -Color: normal; -Temperature: warm; -Turgor: normal (skin returns promptly); -Skin issues: no; -Physician actions: no new orders; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Were the list of medications from the hospital compared with the medications the resident was taking at home: yes; -Was the physician notified if any discrepancies were noted during the medication reconciliation: yes, reconciliation necessary, physician agreed with new medications prescribed by hospital. Review of the admission progress note, a late entry, dated 2/12/25 at 10:16 A.M., showed: -The resident is chairfast. Skin color is normal, skin is warm and dry. No skin issues present. Review of the February TAR, dated 2/1/25 through 2/28/25, showed no wound care orders and no documentation of treatments completed after re-admission on 2/12/25. Review of the re-admission Physician Order Sheet (POS), showed: -An order dated 2/13/25: wound care specialist to eval and treat if indicated; -No orders noted for Juven. Review of the Braden (a tool used to determine the person's risk to develop pressure injury) score, dated 2/17/25, showed: -Sensory perception: ability to respond to pressure related discomfort: 3, slightly limited; -Moisture: degree to which skin is exposed to moisture: 3, occasionally moist; -Activity: degree of physical activity: 2, chairfast; -Mobility: ability to change and control body position: 1, completely immobile; -Nutrition: probably inadequate: 2, rarely eats a complete meal; -Friction and shear: 2, potential problem; -Score: 13, moderate risk. Review of the progress notes, dated 2/17/25 at 1:25 P.M., showed a weekly skin observation note: late entry: the skin color is normal. Skin temperature is dry and warm. Skin turgor is normal as skin returns promptly. Skin issues present, refer to assessment. Review of the weekly skin assessment, dated 2/17/25 at 1:25 P.M., showed: -Skin color: normal; -Skin temperature: dry and warm; -Skin turgor: normal, skin returns promptly; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Skin issues: yes; -Skin condition: -Right buttock: incontinent associated skin dermatitis; -Left buttock: incontinent associated skin dermatitis; -Sacrum: reddened area; -No additional progress notes included. Review of the progress note, dated 2/17/25 at 2:50 P.M., showed: -A medication administration note: hydrocodone 5 milligram (mg)-325 mg (a narcotic pain reliever for moderate pain) administered for coccyx pain; -No additional notes regarding assessments, treatment or physician notification. Review of a nurse progress note, dated 2/20/25 at 2:37 P.M., showed the resident continued therapy and cooperative with care. The dressing on the coccyx changed and well tolerated. Redness noted to the groin, applied powder. The resident turned and repositioned in bed. (Note: Review of the February TAR, dated 2/1/25 through 2/28/25, showed no wound care orders and no documentation of treatments completed.) Review of the skilled nursing note, dated 2/20/25 at 2:41 P.M., showed: -Alert to person, place, time and situation; -Skin integrity: -No new changes to skin integrity noted; -Wound care: -The resident has treatable wounds -No further description as to number, type, location; -Dressing changed as per treatment orders: unselected; -Dressing change not required: unselected; -Changed were noted to wound: unselected. Review of the POS, showed: -An order, dated 2/20/25: wound consult to treat related to open area on the coccyx; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-No orders noted for Juven supplement. Review of the progress notes, dated 2/23/25, showed: -At 11:45 A.M.,: pain to the bottom, barrier cream applied; (Note: the resident did not have any order for barrier cream) -At 1:34 P.M., medication note: Hydrocodone 5 mg, one tablet administered for buttock pain. Review of the weekly skin assessment, dated 2/24/25, showed: -Skin color: normal; -Skin Temperature: dry and warm; -Skin turgor: normal, returns promptly; -Skin issues: yes; -Skin condition: site: -Right buttock: incontinent associated dermatitis; -Left buttock: incontinent associated dermatitis; -Sacrum: reddened area; -Note: skin is normal. Temperature is dry and warm. Skin turgor is normal as skin returns promptly. Skin issues present, refer to assessment for more information. Review of the progress notes on 2/28/25, showed: -At 12:44 P.M., a nurse note: pain assessment every shift: buttock pain; -No noted further assessment documented; -At 1:21 P.M., a medication administration note: Hydrocodone administered for buttock pain; -At 5:30 P.M., a late physician visit note: no notification of wound or skin impairment to buttocks. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/2/25, showed: -Cognitively intact; -Range of motion impaired upper and lower extremities; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Dependent of staff for hygiene, bathing, dressing, bed mobility and transfers; -Diagnosis included: Parkinson's disease, malnutrition, anxiety and depression; -At risk for PU; -Unhealed PU: no; -Other problems: moisture associated skin damage (MASD, skin inflammation and erosion caused by prolonged exposure to moisture such as sweat, urine, stool and wound drainage); -Skin treatments: pressure reducing device for chair and bed, ointments applied other than to feet. Review of the POS in effect on 3/2/2025, showed: -No orders for a pressure reducing device in the resident's bed including a low air loss mattress (LAL, used to distribute weight and prevent wound development). Review of the progress notes, dated 3/2/25 at 10:22 P.M., showed a behavior note: the resident refused medication and agitated when staff unable to assist him/her. The resident threatened to call emergency services. Complaints of pain in wounds, administered pain medication and repositioned on his/her side for comfort. The resident refused to allow the nurse to dress the wounds and wanted the area left open to air and stated the bandages sting. Review of the weekly skin assessment, dated 3/3/25, showed: -Skin color: normal; -Skin temperature: dry and warm; -Skin turgor: normal, skin returns promptly; -Skin issues: yes; -Skin condition: -Right buttock: incontinent associated dermatitis; -Left buttock: incontinent associated dermatitis; -Sacrum: reddened area; -Note: skin color is normal. Temperature is dry and warm. Skin turgor is normal as skin returns promptly. Skin issues present. See assessment for more information; -No documented physician notification of skin issues. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan, revised on 3/3/25, showed: -Focus: the resident has a self-care deficit. The resident at times refuses to be placed in bed; -Goal: maintain current level of function; -Interventions: the resident is totally dependent on staff for repositioning and turning in bed, dependent on staff for personal hygiene, toileting and transfers; -Focus: the resident has actual or potential skin impairment; -Goal: the resident will maintain intact skin; -Interventions: staff follow facility protocols for treatment of injuries, staff identify and document causative factors and eliminate/resolve where possible, keep skin clean, dry and intact. Use lotion on dry skin. Focus: nutritional problem: -Goal: the resident will comply with diet for weight loss; -Interventions: RD to monitor, staff serve ordered diet and administer medications as ordered. Review of the weekly skin observation, dated 3/10/25, showed: -Skin color: normal; -Skin temperature: dry and warm; -Skin turgor: normal, returns promptly; -Skin issues: yes; -Skin condition: -Right buttock: incontinent associated dermatitis; -Left buttock: incontinent associated dermatitis; -Sacrum: reddened area; -Note: skin color is normal. Skin temperature is dry and warm. Turgor is normal as skin returns promptly. Skin issues present, see assessment for details; -No documented physician notification of skin issues. Review of the physician visit note, dated 3/10/25 at 11:16 A.M., showed no documented notification of skin issues. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes, dated 3/12/25 at 9:52 A.M., showed a Registered Dietician (RD) note: skin intact. Review of the weekly skin assessment, dated 3/17/25, showed: -Skin color: normal; -Skin temperature: dry and warm; -Skin turgor: normal, returns quickly; -Skin issues: yes; -Skin condition: -Right buttock: incontinent associated dermatitis; -Left buttock: incontinent associated dermatitis; -Sacrum: reddened area; -Note: the skin is normal. Skin temperature is dry and warm. Skin turgor is normal as skin returns promptly. Skin issues present. Refer to assessment for more information; -No documented physician notification. Review of the physician visit progress notes, dated 3/18/25 at 12:50 P.M., showed no notification of skin issues or concerns, and no documentation of any refusals to see WCP in his/her record. Observation and interview on 3/19/25 at 9:00 A.M., showed the resident up in the motorized wheelchair. He/She said he/she returned to the facility from the hospital on 2/12/25. Before the hospital stay, staff applied cream to his/her bottom. During the hospital stay, the hospital applied a cream treatment to his/her bottom and took photos of the wounds. Since he/she returned to the facility on [DATE], staff had not applied any treatments to his/her bottom. He/She is incontinent of bowel and used a catheter. His/Her bottom hurts and staff said he/she had wounds. He/She had not seen a wound specialist. At times, a nurse would apply gauze to his/her buttocks. When aides remove the gauze, it is painful. He/She does not like to lie down after getting up, because staff will not get him/her back up for meals, and he/she will remain in bed until the next day. The resident's bed did not have a LAL in place and the center of the mattress was noted to be sunk in. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 3/20/25 at 7:30 A.M., showed the resident awake in bed. He/She lay on a standard mattress. CNA D and CNA E assisted the resident onto his/her side and exposed the buttocks. Noted to the sacrum, on his/her left and right buttock were multiple white gauze pads and foam dressings secured by gauze, undated and no staff initials were observed. Blood was noted to various areas of the gauze. CNA D and E said oh my God, (he/she) is bleeding, these are stuck to (him/her), CNA D used a warm soapy washcloth and squeezed the water onto the adhered gauze pads and slowly removed the gauze from the resident's skin. The resident yelled oh God, that hurts CNA D and E apologized and continued to remove the bandages. The resident requested the aides spray Bactine (pain relieving over the counter spray) spray and said the spray helps numb it. CNA D cleansed the entire buttock area and sprayed the area with Bactine. CNA E said he/she cared for the resident last week and reported the open wounds to the nurse. At 7:42 A.M., CNA E left the room and re-entered with Licensed Practical Nurses (LPN) B and C. LPN B said he/she worked the night shift and staff did not notify him/her of the wounds. He/She turned the resident in bed. The resident did not have active wound care orders. LPN C said he/she had just received report from LPN B. LPN B had not reported any skin issues. Both LPN B and C said the resident had various open areas and dark wounds to the buttocks, several areas were noted to be actively bleeding. LPN B and C added the resident had no current wound care orders and did not know how the dressings were applied to the resident's buttocks. The resident should have wound care orders to apply any treatments. The resident will be seen by the wound care specialist today. Review of the March TAR, dated 3/1/25-3/31/25, showed no wound care orders or treatments. Observation and interview on 3/20/25 at 7:55 A.M., showed the Assistant Director of Nursing (ADON) entered the resident's room. She asked the resident if he/she would be seen by the wound care specialist and the resident consented. Outside of the resident's room, the ADON said he/she has worked as the floor and she was familiar with the resident. The resident frequently refuses to lie down between meals and had refused to be assessed by the Wound Care Plus Nurse Practitioner (WCP NP). The resident refused to allow staff to apply ointments to the wounds. The ADON said the weekly skin assessments should be accurate to the current skin condition. The care plan should reflect the current skin condition. All refusals should be documented in the medical record. The resident did not have any current wound care orders as of his/her re-admission on 2/12/25. The hospital wound orders should have been carried over to the facility TAR and POS. She noted the hospital orders were missed. The ADON said the resident's bottom had various open areas noted to be bleeding and several dark wounds. The initial re-admission skin assessment should have accurately reflected the skin condition and staff should have documented the wounds appropriately including measurements and the physician should have been notified. The ADON said the WCP NP would be coming today to assess the resident's wounds. The resident did not have a LAL in use and the facility would apply a LAL if the WCP NP ordered one. The facility did not apply LAL to residents at risk to develop pressure wounds, but relied on assessment from the WCP team. Observation and interview on 3/20/25 at 9:47 A.M., showed the WCP NP said this was the first time she saw the resident since his/her re-admission in February. She had been told by the facility the resident had previously refused WCP consult. She did not speak to the resident regarding the refusal. The WCP NP obtained the following: -Right buttock: 6.0 cm x 4.2 cm x 0.2 cm. Slough (yellow, stringy moist unhealthy tissue that impedes health and can increase risk of infection) 15 percent (%), granulation (new, pink healing tissue) 60%; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Sacrum: 5.6 cm x 5.0 cm x 0.2 cm. Slough 10%, 50% granulation; -Left buttock: 5.5 cm x 4.5 cm x 0.2 cm. Slough 25%; -All wounds are considered Stage III (involves full thickness skin loss with damage or necrosis (black, hard dead tissue) of subcutaneous tissue (fat), presenting as a deep crater, but without exposure to bone, tendon or muscle) pressure injuries; -New orders: Clean wounds daily with wound cleanser, apply Santyl (used to debriding (removing dead tissue) from wounds), cover with calcium alginate (CA, used to absorb wound drainage and promote a healing wound environment), and staff apply a LAL mattress. The resident educated on importance of lying down and off-loading between meals. During an interview on 3/20/25 at 12:04 P.M., CNA F said he/she noted the buttock wounds three weeks ago. He/She told the nurse. The wounds were smaller at that time. The resident does not like to lie down during the day. The resident's current mattress is not an LAL and is sunk in the middle of the mattress. He/She had assisted with the resident's care the last few weeks and noted saturated dressings to the buttock wounds. He/She reported saturated dressings and the mattress to the nurse. During an interview on 3/26/25 at 10:07 A.M., the Regional Therapy Director said the resident received therapy two to three times a week at the facility and had not missed any sessions. The resident is dependent on staff for bed mobility and transfers. She is not familiar with the therapy department staff determining resident mattress recommendations, and said it is usually a nursing and wound care team task. Therapy would make bed mobility recommendations such as side rails. The resident is very limited in bed mobility and unable to turn and reposition himself/herself due to quadriplegia. 2. Review of Resident #16's admission MDS, dated [DATE], showed: -readmitted [DATE]; -Able to make needs and wants known; -Needs staff assistance for bed mobility, dressing and toileting; -Frequently incontinent of urine and always incontinent of bowel; -Diagnoses included: severe protein malnutrition, pressure ulcer right hip, left hip, left heel, muscle wasting, and kidney failure. Review of the POS, showed the following wound care orders, dated 1/25/25: -An order to the left heel: cleanse with hydrochlorous acid (used as an antibacterial cleanser), apply CA and cover with bordered gauze. Change daily and as needed (PRN); -An order, to the left posterior (back) thigh: cleanse with hydrochlorous acid, apply CA and cover with bordered gauze. Change daily and as needed (PRN); (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-An order, to the right posterior thigh: cleanse with hydrochlorous acid, apply CA and cover with bordered gauze. Change daily and as needed (PRN). Review of the February and March 2025 TAR noted treatments completed as ordered. Review of the WCP NP, visit notes, dated 3/13/25, showed: -Left heel: -Measurements: 0.6 cm x 0.6 cm x 0.2 cm; -Slough: 10%; -Stage III; -Left posterior thigh: -Measurements: 3.5 cm x 2.0 cm x 0.2 cm; -Slough: 5% -Stage III; -Status: stayed the same compared to previous visit; -Right thigh posterior: -Measurements: 5.0 cm x 9.8 cm x 0.2 cm; -Slough 20% -Stage III; -Left lateral thigh: -Measurements: 0.7 cm x 0.8 cm x 2.8 cm; -Slough 15%; -Stage III; -Orders remain the same, change dressing daily and as needed for saturation and soiling. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 3/19/25 at 8:50 A.M., showed the resident lay in bed on a LAL mattress. He/She said he/she was admitted to the facility with multiple wounds. He/She had been seen by the WCP NP weekly. The facility staff do not change the dressings daily and his/her wound dressings had not been changed for several days. CNA G assisted the resident onto his/her side and exposed the buttocks. CNA G said oh, those are draining onto the bed pad. A saturated wound dressing was noted to the right and left posterior thigh, the left lateral thigh and the left heel wound noted as uncovered and no dressing in place. CNA G said he/she would notify the nurse. The saturated dressings were undated and had no staff initials observed on the dressings. Review of the progress notes on 3/19/25 at 11:20 A.M., showed no documentation of wound care or saturated dressings changed. Observation and interview on 3/19/25 at 11:39 A.M., showed the resident in bed. He/She said the nurse had not changed the wound dressings that were observed earlier in the morning. During an interview on 3/19/25 at 1:30 P.M., the resident said the nurse just changed the saturated dressings a few minutes ago. 3. During an interview on 3/20/25 at 1:08 P.M., the Director of Nursing (DON) said the facility does not have a wound care nurse and the floor charge nurses are expected to complete wound care orders. Admission skin assessments should be accurate and reflect the current skin status. Hospital discharge orders should be carried over into the facility orders and verified by the physician. Weekly skin assessments should be an accurate account of current skin conditions. The DON said she discovered Resident #14's wound care orders had not been continued after his/her re-admission on 2/12/25. He/She forgot to add the missed wound care orders onto the February POS. The resident had no current wound care orders prior to WCP NP seeing the resident today. The wounds had worsened since the hospital re-admission. The resident refuses to lie down between meals. Aides should not apply any form of medication to residents without orders and consulting with the charge nurse. All refusals should be documented in the progress notes. All saturated dressings should be changed within an hour of staff notifying the nurse. Leaving saturated dressings on a wound could increase the risk of infection. Residents at risk to develop, or those that have, wounds should have a LAL mattress to help prevent development or worsening of wounds. Staff are expected to obtain orders upon the discovery or changes to a wound. MO00250558 MO00250724 MO00250777 44950

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on interview and record review, the facility failed to follow their policy for Elopement and Wandering for one resident (Resident #1) when the resident eloped (left the premises without authorization and/or any necessary supervision to do so) from the facility. The facility considered the resident leaving Against Medical Advice (AMA), although the resident had a legal guardian and was unable to make medical decisions on their own. Facility staff did not have a consistent understanding of the difference between a resident having a leave of absence, elopement, and against medical advice, to ensure policies and procedures were followed accordingly. The resident sample was 13. The census was 144. Review of the facility's Discharge Against Medical Advice policy, last revised 10/24/22, showed: -A resident may discharge themselves from the facility against the advice of his/her physician; -The facility and/or physician will discuss with the resident and/or the resident's representative, if applicable, the reason for AMA decision and will advise them of the potential consequences of the AMA decision; -No medications are dispensed to a resident leaving AMA; -Nursing staff will document in the progress notes all pertinent information concerning the resident's actions, including the resident's stated reason for his/her desire to leave the facility; -The AMA policy did not address residents who were deemed incompetent and/or had a legal guardian and were unable to make the decision to leave AMA. Review of the facility's Wandering and Elopement policy, last revised on 10/24/22, showed: -If facility staff observes a resident leaving the premises without having followed proper procedures, he/she may: Try to prevent the departure, get help from other facility staff in the immediate vicinity, direct another facility staff member to inform the charge nurse or Director of Nursing (DON) that a resident is trying to leave the premises; -Return of a Resident - When an individual who departed without following proper procedures returns to the Facility, the Director of Nursing Services or Licensed Nurse should: --Examine the resident for nay possible injuries; --notify the attending physician; --notify the resident's responsible party. (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-The licensed nurse will initiate or update the resident's care plan and implement immediate intervention(s) to prevent further wandering/elopement by the resident.

-The IDT, with input from the licensed nurse, will conduct a thorough review of the elopement, document its findings in the IDT notes, and update the Care Plan to prevent a recurrence.

-The Quality Assessment & Assurance Committee will review all instances of elopement.

-The policy did not indicate that a resident who has been deemed incompetent and who leaves the facility without following proper protocol as leaving AMA and did not instruct staff to discharge the resident instead of following the Wandering and Elopement policy;

-The policy did not define elopement.

Review of Appendix PP State Operations Manual, showed:

-Definition for resident-initiated transfer or discharge: Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. Leaving the facility does not include the general expression of a desire to return or the elopement of residents with cognitive impairment;

-Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.

Review of Resident #1's Circuit Court Petition to Appoint Successor- Guardian, showed:

-On or about May 28, 2013, the court found Resident #1 to be incapacitated and appointed Guardian A, as guardian;

-Due to health and other reasons, Guardian A wishes to resign as guardian and asks the court to appoint Guardian B as successor guardian.

Review of the resident's face sheet, showed:

-admitted on [DATE];

-Diagnoses included type II diabetes, psychotic disorder with delusions due to known physiological condition, cocaine dependence, paranoid schizophrenia (mental disorders characterized in disruptions in thought process, emotions, and social interactions), post-traumatic stress disorder (PTSD, mental health condition that is caused by an extremely stressful or terrifying event), borderline personality disorder (condition characterized by intense and unstable emotions, impulsive behaviors, and difficulty maintaining healthy relationships), moderate intellectual disabilities, and anxiety disorder;

-Has a guardian;

-discharged on [DATE].

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 9/19/24, showed: -Focus: Resident is not allowed to go Leave of Absence (LOA) from facility with anyone per guardian request; -Goal: Guardians wishes will be honored and protective oversight will be ensured; -Interventions: Guardian will re-evaluate LOA privileges once the resident is acclimated to facility; -Inform and notify staff that resident is not allowed to go LOA. Information given to resident, receptionist, and nursing staff; -No documentation of the resident's history of wandering or elopement risk. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/23/24, showed: -Cognitively intact; -Diagnoses included high blood pressure, acid reflux, diabetes, hyperlipidemia (high level of lipids in the blood), malnutrition, anxiety, psychotic disorder, schizophrenia, PTSD; -Independent with mobility; -No behaviors; -Has resident wandered: Behavior not exhibited. Review of the resident's progress notes, showed: -On 10/10/24 at 3:19 P.M., documented by Licensed Practical Nurse (LPN) D, showed resident went to activities and left the facility. Assistant Director of Nursing (ADON) was made aware; -On 10/10/24 at 5:06 P.M., documented by Assistant Director of Nursing (ADON) showed resident left against medical advice after being educated on the risk of leaving Against Medical Advice (AMA). Contacted Guardian B in which he/she was in agreement with decision made. Contacted Physician K and Physician L in regard to AMA status and stated ok. Review of the resident's Against Medical Advice Discharge form, dated 10/10/24, showed: -Resident refused to sign with education provided; -Verbal consent from Guardian B; -Signed by ADON on 10/10/24. Review of the facility's investigation, showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Date of Incident: 10/10/24; -Type of Incident: AMA discharge; -Initial investigation: Resident had a diagnoses of, but not limited to, Borderline Personality disorder, high risk heterosexual behavior, herpes viral infection, paranoid schizophrenia, diabetes, history of cocaine dependence, generalized anxiety disorder, mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age), moderate intellectual disabilities, and PTSD. Resident has a BIMS of 15 (cognitively intact). At admission, resident deemed a low risk for elopement; -Resident attended an activity off the unit. He/She went to use the bathroom and attempted to leave the facility. She was asked to sign out, but refused. He/She was also asked to sign out AMA if he/she was leaving. Resident refused to sign out AMA after attempted education and left facility with his/her boyfriend in a black sedan at 2:34 P.M. ADON notified guardian of AMA and stated he/she was not surprised by his/her behaviors; -Findings: Resident refused to follow Against Medical Advice policy. Resident refused to sign AMA form after given education on the risks of leaving AMA; -Conclusion: Resident refused to sign AMA. If resident shows interest in returning to the facility, he/she will need to follow our admission process as a new referral. Receptionist is aware that resident is not allowed to return until admission process has been completed. Guardian is supportive regarding AMA and re-admission process and lack of being readmitted as resident's behavior are mirroring the same as [AGE] years ago; -AMA: Resident ran out of facility AMA appropriately 2:34 P.M.; -Staff attempted to have resident sign AMA paperwork although resident did refuse and had things to do; -Review of the facility's investigation showed no statement from staff who attempted to stop resident from leaving; -No written statement from the receptionist; -No written statement from the ADON. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/7/25 at 10:15 A.M., Receptionist M said he/she worked as receptionist at the time of the incident. From his/her understanding, something was going on in activities. The resident plotted to leave. The resident went into the bathroom and came out, but wore a jacket with hood and had a purse on his/her shoulder. The resident was dressed and looked like a visitor. He/she booked it down the hall and walked by Receptionist M. Since he/she never seen him/her before, so Receptionist M thought it was a visitor. The resident stood at the front door with his/her back facing the receptionist desk. The resident stood there for several seconds. The resident looked like a visitor that was waiting at the door. The front entrance door system is not that good because if someone stuck their finger in between the small opening between the two doors, the doors open. That was how the door opened. Receptionist M saw the resident walk across the street, entering a parked car. The car drove away quickly. There were a lot of staff in the classroom at the time that saw the resident walk across the street. They came out and said the resident eloped, and receptionist said, who. He/She never saw the resident before that. At the time of the incident, it was an elopement and not AMA. There was no one that stopped the resident, spoke to the resident about AMA prior to the resident exiting the building, and the resident did not sign a form before leaving. The resident tried to return to the building, but they denied him/her. Review of a form titled Against Medical Advice Discharge Form, dated 10/10/24, showed two places for the resident's signature. Under the first section, Resident #1 refused to sign the form acknowledging the risks involved and danger to health and safety if they left the facility, and releasing the facility and administration from responsibility. Under the 2nd section under a statement, Authorization must be signed by the resident, by the nearest relative in the case of a minor, or by the Durable Power of Attorney when the resident is physically or mentally incompetent., showed the resident's signature and a statement verbal consent via (name). During an interview on 2/5/25 at 12:56 P.M., the ADON said he/she remembered the resident. The resident was alert and oriented x 4 and had been in nursing homes for a long time. He/She was young and outgoing. He/She had mental issues and substance abuse, which was why he/she was on the secured unit. The resident was not an elopement risk. He/She was completely functioning and could tell you anything. There was nothing said that would alarm him/her as an elopement risk. The resident liked activities. The ADON worked on 10/10/24, but did not witness the resident attempting to leave or trying to leave. The ADON did not know who tried to stop. The ADON was asked who reported that the resident was leaving and he/she said, staff, but could not remember who. The resident wanted to leave AMA. He/she had a boyfriend on the outside. The resident wanted to leave AMA, his/her guardian was called. The ADON contacted the guardian, educated the resident on the importance of not leaving AMA. The guardian was also educated on leaving AMA in general without speaking to the physician. The resident wanted to leave with his/her boyfriend. The ADON contacted the guardian because the resident was not his/her own responsible party and ADON wanted to make sure it was okay. The ADON presented the AMA form to the resident and he/she signed it without any concerns or issues. A couple of days later, he/she came back for her belongings with his/her family. ADON contacted the physician and guardian and informed staff. They were not told the resident could not return. That was their decision when they returned to the facility. If a resident leaves the building, without staff knowledge, did not sign out, that is considered an elopement. The ADON was asked if the resident exited the facility before the guardian was contacted. The ADON could not remember if the resident was still in the facility when the guardian was contacted, but remembered that the resident was in the process of leaving. The resident was physically in the building when the guardian was called. After the resident signed the AMA form, he/she gave it to the Administrator. The ADON confirmed there were no issues when the resident signed the AMA form. The resident did not refuse to sign. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 10:45 A.M., Guardian B said the resident was supposed to be in a secured area. The resident went downstairs for something. Guardian B does not know how the resident walked out the door or if he/she got a ride with someone, but Family Member C found the resident. The resident and Family Member C returned to the facility and staff told them that the resident could not come back. The resident was taken to a local hospital and the resident has been there ever since. Someone from the facility did call him/her and Family Member C. There was no discussion about AMA. The resident was gone for two days. When Family Member C brought the resident back, whomever met them at the door told them they could not come back. Staff packed up the resident's belongs. The resident came from a facility that closed and he/she did elope from the prior facility. During an interview on 2/4/25 at 11:00 A.M., Family Member C said the facility called him/her the day he/she left and asked if he/she had the resident. He/She told the facility, no. There was no further discussion at that time. Another staff called later and said the resident was not at the facility, that he/she ran out the door and hopped in a car. The next day, the resident called him/her and asked him/her to come and pick the resident up. He/She asked the resident what happened, and the resident said he/she called a guy and told him to get him/her, then he/she ran out of the building, hopped in the car, and said go, go, go! He/She had escaped this place. Family Member C took the resident back to the facility and staff said they would not take the resident back. Family Member C asked staff where they should take the resident, and staff said that is the guardian's responsibility. Family Member C took the resident to the hospital psychiatric ward and that is where he/she still is. There was no discussion about AMA and they did not ask him/her to sign anything. They handed him/her belongings and a bag of medication. During an interview on 2/4/25 at 11:35 A.M. and 2/5/25 at 11:43 A.M., LPN D, the resident's nurse at the time of the elopement, said he/she does remember the resident. The resident and one other resident were admitted from a nursing home in Arkansas. He/She was the staff person who drove to pick them up. During the ride back, the other resident informed him/her to watch because Resident #1 runs off. He/She was aware the resident was at risk for elopement. The resident said he/she was going to an activity. Activity staff took the resident downstairs. About 15 to 30 min later, activity staff said the resident was gone. Staff informed him/her the resident ran out the front door and got into a car. The front desk staff saw it. The resident did not tell anyone and he/she was supposed to be watched at all times. Staff was told the resident would run when he/she was admitted . He/She notified the Assistant Director of Nursing (ADON) and DON E, who was the DON at the time. The DON notified the family that the resident had left. The resident left his/her belongings upstairs. LPN D first said this incident was an elopement, then said if a resident on a locked unit leaves without telling staff it is AMA and not elopement, so now he/she thinks it was AMA because the resident was diabetic and had medical issues. Elopement means they just take off. The resident did not sign out and did not say anything about leaving. Activity staff were supposed to watch the resident. During an interview on 2/4/25 at 1:47 P.M., CMT I said he/she was working the day the resident left. Resident #1 left the floor with activity staff. The next day he/she was made aware the resident was gone. He/She heard the resident went to the bathroom, came out, and left. Staff never heard him/her say anything about leaving. He/She was not aware if the resident was an elopement risk. It was just reported that he/she left and was seen getting into a car. If a resident leaves without telling anyone and runs out of the building into a car, it is an elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 1:30 P.M., Activity Director H said Resident #1 was seen running out the door. Staff reported he/she came out of the bathroom and ran up the hall. The aide said the resident got out and got in the car. He/She saw the resident when family brought him/her back. He/She looked rough like he/she was under the influence. He/She asked the resident why he/she did that and resident said he/she did not know why. Activity staff are responsible for protective oversight. Residents cannot go outside without staff. To his/her knowledge the resident was not an elopement risk. It was not an elopement because the resident was in activities at the time, he/she did not escape from the unit. If a resident leaves it is AMA, only if they are their own responsible party. It would be an elopement if the resident had a guardian. Resident with a guardian cannot leave AMA. During an interview on 2/5/25 on 9:30 A.M., Nurse Practitioner (NP) J, the NP for Physician K, said the resident came from another facility. He/She had a drug problem and has schizophrenia. He/She was alert and oriented, able to tell staff where he/she was, but he/she was not sure if the resident had a guardian. The facility told him/her the resident left AMA and was educated, but the resident still decided to leave. If the resident had a guardian and left the facility, that would be an elopement. He/She would expect the facility staff to understand the difference between elopement and AMA. If a resident leaves, does not sign out, and does not have a discussion about leaving, it is an elopement. It would not be appropriate for a resident to leave without staff knowledge or guardian knowledge and determined it was AMA, it would be an elopement. During an interview on 2/4/25 at 2:09 P.M., with the administrator, Regional Nurse, and Director of Clinical Reimbursement Services, they said they define elopement as an unauthorized, unwitnessed leave. If staff does not have eyes on them, guardian does not know, and they leave. The Regional Nurse said in this instance, she believes it was AMA because the resident was told to sign out. The Director said when the resident left, he/she was in activities. He/She wanted to leave and staff tried to stop him/her. They talked to him/her about signing out and he/she did not want to sign out. They then pulled up AMA paperwork. They contacted the responsible party and they said they knew he/she would do this. During an interview on 2/5/25 at 1:20 P.M., Receptionist G said if a resident runs out of the building, does not notify staff, and gets into a car, it's an elopement. They ran off and did not tell anyone. They have an elopement binder at the front desk. During an interview on 2/6/25 at 10:06 A.M., Certified Nursing Assistant (CNA) V said an elopement is when a resident leaves the facility without staff knowledge. During an interview on 2/6/25 at 10:23 A.M., CNA U said he/she did not know the difference between an elopement and AMA. The two run together. During an interview on 2/6/25 at 10:23 A.M., CNA T said the code for an elopement is gray. At 10:41 A.M., he/she wanted to change their answer. It used to be yellow, but now it is pink. An elopement is when a resident leaves without anyone knowing, right out of the door. Observation on 2/6/25 at 10:23 A.M., showed an elopement in-service posted on the door outside the entrance to the unit. The code was pink. During an interview on 2/6/25 at 10:31 A.M., CNA S said he/she did not know the difference between elopement and AMA. He/She had trouble with the two. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 10:36 A.M., CNA R said an elopement is when a resident left the building without staff knowing. They would do a head count, lock down the floor, and notify the supervisor. The code is pink. During an interview on 2/6/25 at 10:39 A.M., Certified Medication Technician (CMT) Q said an elopement is when a resident escapes. They would call a code pink. During an interview on 2/6/25 at 10:24 A.M., LPN D said he/she had trouble differentiating between elopement and AMA. The color code used to be gray. At 11:43 A.M., LPN admitted it was difficult distinguishing between elopement and AMA because of how it was presented to him/her when Resident #1 eloped. During an interview on 2/6/25 at 12:27 P.M., the Administrator said she would expect staff to understand the difference between elopement and leaving AMA. Staff are expected to discuss AMA with the resident, notify the guardian/family, physician, and present the resident with an AMA form. She would expect staff to follow discharge policy and for all residents to be properly discharged from the facility. If the resident returned to the facility, she would expect staff to document it in the record. MO00248299

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility failed to ensure the respiratory services provided were consistent with professional standards of practice for one resident (Resident #3) when staff failed to ensure the oxygen was in working order when it was administered to the resident who had shortness of breath. The facility called Emergency Medical Services (EMS), who found the resident hypoxic (low level of oxygen) and the oxygen was not turned on. In addition, the facility failed to ensure staff followed physician's orders for the rate of oxygen and failed to properly change and date oxygen tubing (Resident #2). The facility identified three residents with orders for oxygen. The sample size was 13. The census 144. Review of the facility's oxygen administration policy, revised 10/24/22, showed: -Initiation of Oxygen: A physician's order is required to initiate oxygen therapy, except in an emergency situation. The order shall include: -Oxygen flow rate; -Method of administration (e.g. nasal cannula); -Usage of therapy (continuous or as needed (PRN)); -Titration instructions (if indicated); -Indication for use; -In an emergency situation or when a physician's order cannot be immediately obtained, oxygen may be initiated by a Licensed Nurse in the presence of acute chest pain or any other acute situation in which hypoxia is suspected; -A physician is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations, for verification and documentation of the order for oxygen therapy consultation, and further orders; -Oxygen saturations will be measured and documented at a minimum of daily for residents receiving oxygen therapy; -Procedure: Explain the procedure to the resident; -Check the physician's order; -Wash hands; -Assist resident to semi- or high Fowler's position (sitting posture in bed) , if tolerated; -Attach oxygen tubing to nozzle on flowmeter; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If using a high oxygen flow (> 4 liters), attach humidifier to the flowmeter; -Attach oxygen tubing to humidifier; -Turn on the oxygen at the prescribed rate; -Check that oxygen is flowing through tubing; -For nasal cannula: Hold nasal cannula in proper position with prongs curving downward; -Place cannula prongs into nares (nostrils); -Wrap tubing over and behind ears; -Adjust plastic slide under chin until cannula fits snugly; -Oxygen saturation levels as indicated; -Patient's response to oxygen therapy; -Turn off oxygen when not in use. 1. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 1/12/25, showed: -Cognitively intact; -Diagnoses included high blood pressure, diabetes, dementia, anxiety, depression, malnutrition, asthma, schizophrenia (serious mental illness) psychotic disorder; -Impairment on one side of the lower extremity; -Independent with mobility and transfers. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has chronic obstructive pulmonary disease (COPD, lung diseases)/asthma; -Goal: Resident will be free of signs and symptoms of respiratory infections; -Interventions: Give aerosol or bronchodilators (medications that relax the muscle lining in the airways) as ordered. Monitor/document any side effects and effectiveness; -Monitor for difficulty breathing on exertion. Remind resident not to push beyond endurance; -Monitor/document/report as needed any signs and symptoms of respiratory infection. Review of the resident's progress notes, showed: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 1/30/25 at 7:53 P.M., patient returned to the facility accompanied by his/her daughter. The daughter stated that patient had a colonoscopy scheduled today that was canceled related to fever and low oxygen. Patient was assessed, to exhibit shortness of breath (SOB), oxygen (O2) saturation (sats) fluctuating between 80-83% (normal 95% to 100%) via nasal cannula and temperature 100.9 Fahrenheit (F) (normal 97 F to 99 F). Patient was placed on 2 liters (L) of oxygen and PRN Tylenol was administered. Call was placed to Physician K, orders were given to increase O2 to 4 L and to send patient to emergency room if no improvement; -At 8:23 P.M., crackles present by auscultation (listening to internal sounds of the body, usually with a stethoscope) in the right side of lung. Patient will be sent to hospital for further evaluation. Responsible Party (RP) notified message was left to call the facility concerning patient; -At 8:50 P.M., patient was assessed before being sent to emergency room . No issues noted. Review of the resident's hospital discharge record, showed: -admitted : 1/30/25; -discharge date : 2/5/25; -Principal problems: Hypoxia (low level of oxygen); -Active problems: Influenza A present; - History is obtained from chart review and review of EMS report as patient is not a reliable historian. Patient resides at a nursing home due to his/her dementia. He/She underwent a routine colonoscopy yesterday which was uncomplicated. After returning to his/her nursing facility, the patient reportedly complained of shortness of breath; nursing home staff checked her oxygen saturation of peripheral capillaries (SpO2, measurement of the percentage of oxygen in the blood) which was 79% (resting oxygen saturation level between 95% and 100%). They placed him/her on supplemental 02 without improvement in his/her Sp02, so they called EMS. On EMS arrival, patient was wearing a nasal cannula, but the oxygen had not actually been turned on. After turning on the 02 and bringing the patient up to a seated position, his/her SpO2 improved to 100%. He/She was brought to the emergency department for further evaluation. During an interview on 2/4/25 at approximately 1:30 P.M., the Administrator said she was unaware of any issues regarding oxygen administration. During an interview on 2/6/25 at 11:00 A.M., the Administrator said she would expect staff to ensure the oxygen was turned on and connected accurately to the oxygen port. 2. Review of Resident #2's annual MDS, dated [DATE], showed: -Mild cognitive impairment; -Diagnoses included heart failure, high blood pressure, diabetes, anxiety, depression, asthma, respiratory failure, manic depression, schizophrenia; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No rejection of care; -Receives oxygen therapy. Review of the resident's care plan, in use during survey, showed: -Focus: The resident has oxygen therapy; -Goal: The resident will have no signs or symptoms of poor oxygen absorption; -Interventions: Encourage or assist with ambulation as indicated; -For residents who should be ambulatory, provide extension tubing or portable oxygen apparatus; -Give medications as ordered by physician. Monitor/document side effects and effectiveness; -If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner. Return resident to usual oxygen delivery method after the meal; -Monitor for signs/symptoms of respiratory distress and report to Physician as needed; -Oxygen per physician's orders; -Promote lung expansion and improve air exchange by positioning with proper body alignment. If tolerated, elevate head of bed. Review of the resident's electronic Physician's Orders Sheet (ePOS), showed: -An order, dated 8/8/24, change oxygen tubing weekly and as needed on Tuesday, 10:00 P.M.-6:00 A.M. shift when in use. Date and initial tubing as needed related to chronic obstructive pulmonary disease; -An order, dated 9/5/23, oxygen at 2 L per nasal cannula as needed for shortness of breath. Observation on 2/5/25 at 8:40 A.M., showed the resident in bed with his/her eyes closed. The oxygen tubing was on the floor without a label. The nasal cannula was on the floor. The oxygen was turned on and set at 7 L. Observation on 2/5/25 at 1:47 P.M., showed the resident in bed with his/her eyes closed. The oxygen was turned on and set at 8 L per nasal cannula. A sticker, dated 2/4 was on the oxygen tubing. The resident's roommate said they just placed the sticker on it. During an interview on 2/6/25 at 11:43 A.M., Licensed Practical Nurse (LPN) D said the resident uses the oxygen when he/she is asleep. He/She has sleep apnea. He/She is okay during the day. The oxygen is set at 2 L per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/25 at 12:27 P.M., the Administrator said she would expect staff to follow physician's orders. She would expect staff to ensure the oxygen is set per physician's orders and if it needed to be increased, staff are expected to assess the resident, notify the Assistant Director of Nursing (ADON) and physician. MO00248925

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 Based on observation, interview and record review, the facility failed to implement an effective pain management regime for two sampled residents (Resident #18 and #14). Staff failed to notify ensure Resident #18, who experienced pain related to metastatic breast cancer with osseous (bone) involvement, most severe over bilateral lower extremities, received pain medications as ordered by the physician and failed to notify the primary physician when pain medications were not delivered from the pharmacy and of medications available in the emergency kit. The resident experienced uncontrolled pain and was transferred to the hospital two days after admission to the facility. For Resident #14, the facility staff failed to provide effective pain relief when, during care, staff removed wound dressings which were adhered to the wound sites. The resident had so much pain, he/she was observed to cry and requested Certified Nurse Aide (CNA) D spray over the counter Bactine (relieves the pain and itch of minor cuts, scrapes and burns on contact) onto the buttock wound sites. The sample was 16. The census was 145. Review of the facility's Pain Management Policy, revised 10/24/22, included: -Purpose: To ensure accurate assessment an management of the resident's pain; -Policy: A Licensed Nurse will assess residents for pain on admission and routinely as indicated by the resident's health and functional status. Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain; -Procedure: --Pain Assessment: ---A Licensed Nurse will assess each resident for pain upon admission. ---The Licensed Nurse will complete Pain Assessment, or a substantively similar form, for residents identified as having pain within 8 hours of admission. ---The IDT Committee review the Pain Assessment for each newly admitted resident identified by the Licensed Nurse to have pain and at least quarterly thereafter. ---The Licensed Nurse will develop a care plan for pain management, including non pharmacological interventions. ---Pain Flow Sheet, or a substantively similar form, will be completed every shift for new residents for the first seventy-two (72) hours following admission. ---After medications/interventions are implemented, re-evaluate the resident's level of pain within one hour. ---A Licensed Nurse will reassess the resident for pain quarterly and eventfully. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	--Pain Management ---The Licensed Nurse will administer pain medication as ordered and document medication administered on the Medication Administration Record (MAR). ---Nurses will complete the Pain Flow Sheet for residents receiving PRN pain to evaluate the effectiveness of the medication regimen. ---The Licensed Nurse will assess the resident for pain and document results on the MAR each shift using the 1-10 pain scale. ---The shift pain score will indicate the highest pain level that occurred on that shift. ---If there is a new onset of pain, if the pain has changed in nature, or the pain has not been relieved with current medication, the Licensed Nurse will notify the Attending Physician for a review of medications. ---Nursing Staff will implement timely interventions to reduce the increase in severity of pain. ---Nursing Staff will provide education to residents and families as to appropriate expectations for pain management. ---The Nursing Staff will attempt to become familiar with cognitive, cultural, familial, or gender-specific influences on the resident's ability or willingness to verbalize pain. ---Pain Management Tool to audit and assess the success of the Pain Management Program. ---Nursing Staff will also utilize non-pharmacological interventions by adjusting the resident's environment to reduce pain. --Documentation ---Pain Assessments will be maintained in the resident's medical record. ---The Licensed Nurse will document resident's pain and response to interventions in the medical record on the weekly summary and as indicated on the progress notes. ---The Licensed Nurse will update the care plan for pain management with any change in treatment and/or medication. ---Upon admission, quarterly, and eventfully the IDT Committee will meet to review the resident's Pain Assessment. The IDT Committee will document the following: -Summary of event causing the pain; -Root cause analysis; -Referrals, as necessary; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Interventions to prevent future pain Review of the Ordering and Receiving Controlled Medication Policy, dated 1/20, showed: -Policy: --Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and record keeping requirements in the nursing care center, in accordance with federal and state laws and regulations. The nursing care center obtains and keeps current and on file any permits required by state agencies. Procedures: --The director of nursing and the consultant pharmacist monitors for compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medications. --Medications listed in Schedules II, III, IV and V are dispensed by the pharmacy in readily accountable quantities and containers designed for easy counting of contents. When possible, injectable controlled substance medications are dispensed in ampoules or vials of the smallest available dosage unit. (Note: Refer to state regulations, as particular states do not require Schedule V medications to be dispensed in accountable quantities and containers.) --The pharmacy or the nursing care center prepares an individual resident controlled substance record/receipt/log for each controlled substance medication prescribed for a resident as applicable per state law. This log is placed in the MAR or narcotic book to be counted every shift. The nursing care center may designate a particular medication, which is not mandated as a controlled substance by state or federal laws and subject to abuse or diversion, to be handled under these procedures for controlled medications. (Note: Refer to state regulations, as particular states do not require this documentation for Schedule V medications.) The following information is completed: -Name of resident -Prescription number -Medication name -Medication strength (if designated) -Dosage form of medication -Date received -Quantity received -Name of person receiving the medication supply (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	--The Drug Enforcement Agency (DEA) requires that a pharmacy must have a valid prescriber signed prescription in order to dispense controlled substances. A valid written prescription requires patient name, drug name and strength, quantity to dispense, directions for use, date and signature of the prescriber. (Refer to Section 2.2-Controlled Substance Medication Orders). In an emergency situation, verbal authorization may be given by the prescriber to the pharmacist for a new order as described by state law. (Refer to Section 3.4 Emergency Pharmacy Service and Emergency Kits (E-Kits)) --Refill Requests for CIII-CV, and Partial Fill Requests for CII -If one or more refills (CIII-Vs) or a partial fill quantity (CIIs) remains: -Written on a medication order form or ordered by peeling the top label from the label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose, and requested from the pharmacy a minimum of 3 days in advance of need to assure an adequate supply is on hand. -If only one refill remains ([NAME]-Vs) or only a partial fill quantity remains (CII), the pharmacy will simultaneously dispense the remaining fill, and, if necessary proactively seek out a new, complete prescription from the prescriber for future use. The facility may be asked to contact the prescriber for a new prescription upon request for a medication with no remaining fills available. 1. Review of Resident #18's electronic medical record (EMR), showed: -Admission: 3/6/25; -discharged : 3/8/25; -Diagnoses include malignant neoplasm left breast, malignant neoplasm of liver, and acute respiratory failure with hypoxia. Review of the hospital discharge record, showed: -Hospital Course: Acute respiratory hypoxia (not enough oxygen in the tissues in your body) secondary to progression of metastatic breast cancer. -Cancer related pain: Diffuse pain related to metastatic breast cancer with osseous (bone) involvement, most severe over bilateral lower extremities. Regimen was adjusted to morphine extended release (ER) (opioid that treats moderate to severe pain) 15 milligram (mg) twice a day (BID) and oxycodone (opioid that treats moderate to severe pain) 10 mg every 6 hours as needed (PRN), continued on scheduled Tylenol 1000 mg three times a day (TID), gabapentin (used to treat nerve pain) 300 mg BID, and added Flexeril (muscle relaxer used to treat pain and stiffness) 5 mg TID PRN. -Medications at hospital discharge included: -Morphine ER 15 mg BID (last given 3/6/25 at 11:42 A.M.); -Oxycodone 10 mg every 6 hours PRN (last given 3/6/25 at 12:47 P.M.); -Flexeril 15 mg TID PRN (last given 3/6/25 at 11:42 A.M.); (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Gabapentin 300 mg BID (last given 3/6/25 at 9:05 A.M.); -Tylenol 1000 mg TID (last given 3/6/5 at 9:05 A.M.). Review of the admission assessment, dated 3/6/25 at 5:40 P.M., showed: -Date of arrival: 3/6/25; -Time of arrival: 5:35 P.M.; -Was physician notified of the resident's admission: Yes; -Were the resident's medications reviewed with the physician: Yes; -Were there any significant medication issues found during review: No; -Level of consciousness: Alert to situation, time, place; -Mood: Flat; -Pain: Does the resident report pain currently: No; -Most recent pain level: 8 3/7/25 at 6:42 A.M.; -Pain plan: Blank -Admission Actions: Physician/Nurse Practitioner (NP) notified of admission assessment; -Physician/NP Actions: No new orders; -Drug Regime Review (DRR): 3/6/25 at 9:00 P.M.; -Was the list of medications from the hospital compared with the medications the resident was taking at home: Yes; -Was the physician notified if any discrepancies were noted during medication reconciliation: No differences noted; -Were all medications reviewed to ensure that proper labs were ordered: Yes; -Select most accurate statement: Statement by nurse that admission DRR completed with no significant issues identified. Review of the resident's pain assessment, dated 3/6/25 at 6:09 P.M., showed: -Have you had pain or hurting at any time in the last 5 days: Yes; -How much of the time have you experienced pain or hurting over the last 5 days: Frequently; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Pain Effect on sleep: Frequently; -Pain interference with therapy activities: Frequently; -Pain interference with day-to-day activities: Frequently; -Verbal descriptor: Severe; -Staff assessment for pain: None of these signs observed or documented (non-verbal, vocal complaints, facial expressions, protective body movements); -Frequency with which resident complains or shows evidence of pain or possible pain: Daily; -Pain Management: Describe treatment, any side effects, effectiveness: ineffective; -Received PRN pain medications: Blank; -Received non-medication intervention: Blank. Review of the resident's care plan, did not address his/her potential for pain. Review of the resident's Pain Level Summary, showed: -3/6/25 at 9:25 P.M., 0/10 pain; -3/7/25 at 6:42 A.M., 8/10 pain; -3/7/25 at 6:46 P.M., 10:35 P.M., and 11:33 P.M., 0/10 pain; -3/8/25 at 3:38 A.M. and 6:48 A.M., 0/10 pain; -3/8/25 at 10:57 A.M., 1:39 P.M., and 2:03 P.M., 10/10 pain. Review of the resident's Physician Order Sheet (POS), included: -An order, dated 3/6/25, Morphine 15 mg. Give 1 tablet by mouth every 12 hours for pain; -An order, dated 3/6/25, Oxycodone tablet 10 mg. Give one tablet by mouth every 6 hours as needed for pain; -An order, dated 3/6/25, Cyclobenzaprine (Flexeril) 5 mg. Give one tablet every 8 hours as needed for muscle spasms; -An order, dated 3/7/25, Gabapentin 300 mg. Give 300 mg by mouth two times a day for pain; -An order, dated 3/6/25, Tylenol 1000 mg. Give 1000 mg by mouth three times a day for pain. Review of the resident's, March 2025, Medication Administration Record (MAR), showed: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Morphine 15 mg: -Showed given 3/6/25 at 9:00 P.M. and 3/7/25 at 9:00 P.M.; -Marked 9 (other/see progress notes) 3/7/25 at 9:00 A.M. and 3/8/25 at 9:00 A.M. -Oxycodone tablet 10 mg: -Medication not administered to the resident. -Cyclobenzaprine (Flexeril) 5 mg: -Medication not administered to the resident. -Gabapentin 300 mg by mouth two times a day for pain. -3/7/25 at 9:00 A.M., Medication marked 5. No progress note related to medication not administered. -Tylenol 1000 mg by mouth three times a day for pain: -3/7/25 2:00 P.M. Not given. Marked 5 (Hold/See progress note). Review of the resident's electronic medical record (EMR), showed: -An administration note dated 3/7/25 at 3:03 P.M., New admit medication (Tylenol) will be delivered 3/7/25; -An administration note, dated 3/8/25 at 12:47 P.M., Morphine sulfate. Medication on order, pharmacy notified; -An administration note, dated 3/8/25 at 1:39 P.M., Morphine sulfate. Medication on order from pharmacy/new admit. Review of the resident's EMR, showed: -A progress note, dated 3/6/25 at 5:40 P.M., resident was admitted from hospital on 03/06/2025 at 5:35 P.M. Resident is alert. Oriented to place time situation. Mood is flat. Resident is not able to report pain at this time. Physician/Nurse Practitioner notified of admission assessment findings and no new orders noted. Refer to full assessment for more information; -A progress note, dated 3/7/25 at 6:33 A.M., resting in bed No signs of acute distress noted. Complained of general discomfort. Scheduled pain medication given with effectiveness. Plan of care ongoing; -A progress note, dated 3/8/25 at 4:38 A.M., monitoring for new admission status. Remains alert and oriented. Able to make needs known. Resident is making adjustments to new environment; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-A progress note, dated 3/8/25 at 3:15 P.M., resident sent to hospital for uncontrolled pain. Physician, family, Director or Nursing (DON) aware. Review of the facility's Controlled II Emergency Medication Kit, showed: -Morphine Sulfate 100 mg/5 milliliter (ml) solution 30 ml; -Fentanyl (used to treat severe pain) 25 mcg patch; -Oxycodone 5 mg tab; -Oxycodone/Apap (Tylenol) (used to treat moderate to moderately severe pain) 5/325 mg tab and 10/325 mg tab; -Hydrocodone/Apap (used to treat moderate to severe pain): 5/325 mg tab, 7.5/325 mg tab, and 10/325 mg tab. Review of the facility's Controlled III-V Emergency Medication Kit, showed: -APAP/Codeine #3 (used to treat moderate to moderately severe pain); -Tramadol (used to treat moderate to severe pain) 50 mg. Review of the Situation-Background-Assessment-Request (SBAR), dated 3/8/25 at 1:11 P.M., showed: -Situation- Patient in severe pain related to recent lumpectomy, breast cancer: -Started on 3/8/25; -Since started it has gotten worse; -Things that make the condition/symptom worse: unmedicated/pharmacy has not delivered; -Things that make the condition/symptom better: medication; -Treatment for last episode: new admit; -Background: -Resident in nursing home for post-acute care; -Primary diagnosis: left breast cancer; -Other pertinent history: neoplasm liver, neoplasm of vocal cords; -Assessment: -Registered Nurse (RN): Think the problem may be uncontrolled pain; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Licensed Practical Nurse (LPN): The resident appears in excruciating pain; -Request: -Suggest or Request: Transfer to the hospital -Nursing notes: Resident has facial grimacing and furrowed brow in relation to severe pain from lumpectomy/other cancer. -Reported to primary care clinician: 3/8/25 at 1:00 P.M. Observation and interview on 3/19/25 at 11:30 A.M., showed Licensed Practical Nurse (LPN) H open the narcotic box in the nurse medication cart. Resident #18 had one card of Oxycodone with 30 out of 30 pills and one card of Morphine 15 mg with 28 out of 28 pills. (The issue date of the medications was March 8, 2025.) Review of the narcotic book showed nothing signed out for the resident. LPN H said there was an emergency kit (e-kit), but he/she was not sure where it is located. When a resident is a new admission, it typically takes pharmacy about an hour to get medications sent to the facility. During an interview on 3/19/25 at 12:04 P.M., LPN A said if a resident is a new admission and they do not have the medication at the facility, then the nurse can pull the medication from the e-kit. There is a controlled medication e-kit and a regular one. LPN A said when the resident was admitted , the facility did not have his/her medications. They were waiting on the doctor to approve it because pharmacy would not send the medication without doctor approval. LPN A believes the medication was sent to the facility after the resident was at the hospital because he/she never received the medication while he/she was at the facility. The medication was still listed as pending while he/she was here. The resident was sent to the hospital because of his/her pain and the facility not being able to manage it. During an interview on 3/19/25 at 12:46 P.M., the Pharmacist said the facility sent the order for the resident's Morphine 15 mg and Oxycodone 10 mg on 3/6/25 at 1:30 P.M. Usually, if the medication is not covered, there is a billing issue like trying to refill too soon or it is on back order. The Pharmacist believes the morphine was on back order, a card was sent to the facility and now it is on back order again. The Pharmacist said their system shows the pharmacy sent the resident's Morphine and Oxycodone to the facility on [DATE] at approximately 11:00 A.M. Typically, once an order is received, the pharmacy can get it to the facility within an hour. The pharmacy is local. During an interview on 3/19/25 at approximately 1:00 P.M., the controlled log inventory sheet for controlled medication sent from the pharmacy to the facility from 3/1/25 to 3/14/25 was requested from the DON. At 1:42 P.M., the DON said no controlled medication had come in or out for the first floor from 3/1/25 to 3/14/25. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/20/25 at 3:50 P.M., LPN K said he/she admitted the resident to the facility. LPN K did not know what the resident was admitted for , but the resident had a left breast mastectomy. The resident had orders for two different narcotics. He/She called the physician because the hospital did not send the prescriptions. The resident did not get either medication while he/she was here. LPN K is not sure why he/she signed off on giving the medication. LPN K might have just checked it as given to get the screen off red so the admission could be completed. LPN K did not remember giving the resident any morphine. During an interview on 3/20/25 at 11:50 A.M., Certified Nursing Assistant (CNA) I said the resident was at the facility for about a day. The resident called 911 to get out of the facility. CNA I said things were chaotic when the resident was admitted . They could not find things like the resident's oxygen concentrator so he/she thinks the resident got frustrated that they could not do things as quick as the resident would like. Then they had to change out his/her bed. Then the next thing they know, the resident is on the ambulance. The resident did not say what brought him/her to the facility but still complained of pain when he/she left. The resident had complained of pain since he/she got there. The resident just looked tired. The resident was constantly grimacing and said his/her lower back hurt. The resident was always complaining of pain. CNA I remembered the nurse telling the resident that he/she could not have anything else, because it was not time yet and the resident still had a couple hours to go. The resident called his/her son/daughter once and CNA I talked to them. The family member said the resident was uncomfortable. The resident was just having a lot of pain. During an interview on 3/20/25 at 12:28 P.M., Certified Medication Technician (CMT) F said the resident was not there very long. CMT F only went in once when the resident's bathroom call light was going off and did not remember if he/she gave the resident any medications. CMT F did not remember why he/she would not have given the resident a Tylenol. CMT F said when a 5 is charted in the MAR, then a progress note should be entered. The resident was just very quiet. During an interview on 3/20/25 at 12:45 P.M., LPN K said he/she did not really remember the resident. LPN K said the CMT gave the resident his/her medications. When asked about the MAR, LPN K said the resident did get morphine. The resident complained of back pain. The morphine was pulled from the medication cart on his/her card,. It may have been a liquid dose, LPN K cannot recall off hand if it was a liquid or pill form. LPN K said he/she did not pull anything from the e- kit and is unsure if the resident had pain medicine. When a medication is pulled from the e-kit, the pharmacy has to give a code to access the e-kit. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/20/25 at 12:57 P.M., the DON said when a resident is admitted , the nurse is expected to complete the admission assessment and verify medications with the physician. The medications are put in the EMR and then the pharmacy should receive it. If the facility does not have a medication, then she expected the nurse to call the pharmacy. She also expected the nurse to notify management, like the Assistant Director of Nursing (ADON), and the physician. If the medication is a controlled pain type medication and the pharmacy says they do not have a prescription, then get the prescription sent to the pharmacy and sign it out from the e-kit. Once signed out, then the pharmacy sends it. If it is not in the e-kit, staff should call the physician and try to get an order for something different. She expected nursing staff to call the physician and get something else for the resident's pain. She is not sure if Tylenol is stock or not. The DON is not sure of the process but believes when the e-kit is open, the nurse calls the pharmacy to get a code which unlocks the kit. The resident was admitted with pain. She received a call on Saturday the resident wanted to go back to the hospital because his/her pain was uncontrollable. The nurse called the physician and sent him/her out. The DON did not get a call prior to that related to the resident. Staff should have called the physician immediately when the medication did not arrive. She and the ADON reviewed the resident's admission on 3/7/25 and this did not come up. The DON expected a resident's pain to be reassessed within the hour. She would not expect staff to document they gave a medication if they did not actually give the medication. During an interview on 3/20/25 at 1:35 P.M., the ADON said they look at the missed medication report every day. The report is generated by what code is entered and a report can be pulled. The resident was there about a day and a half. The resident came late in the day. For the resident's pain medication, they have a narcotic e-kit with morphine. E-kits are kept on the first floor, and there is one box with a combination code. The process is to call the pharmacy. The pharmacy will give a combination to that box and they will approve doses until they deliver the meds. They have morphine in the e-kit. The nurses should have called the physician to get an order for the liquid pain medication. A nurse should not document a medication was given if the medication was not in the building and should not borrow any medications from other residents. The nurses have access to what is in the e-kit as it is on the e-kit box. When staff pull out of the e-kit, it is faxed to the pharmacy, then the pharmacy would know what to replace. The nurse should document a progress note if the e-kit was accessed for a medication. During an interview on 3/20/25 at 9:45 A.M., the NP said he/she did not have a chance to assess the resident in person. The resident came and went. Usually when a patient comes, they send medications, but they did not have the chance. The resident was in bad shape. They did not get a call from the pharmacy regarding the resident's pain medications. The facility did not call either. If a patient needs pain medication, the NP expected a phone call. They have to let the doctor know. They always look for another option if the resident does not have ordered pain medication. If a resident has pain and is not covered/available, then the doctor will give an alternate prescription. 2. Review of Resident #14's medical record, showed: -readmitted [DATE]; -Diagnoses included: quadriplegia (paralysis in all limbs), Parkinson's (a neurodegenerative disease causing muscle weakness and loss), diabetes, anxiety, muscle wasting, and reduced mobility; -Able to make needs and wants known. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the hospital's discharge summary, dated 2/12/25, showed: -admitted : 2/5/25; -Diagnoses: Pneumonia and sepsis; -Wound dressing paste: apply one application topically twice a day to right buttock and left thigh wounds; -Wound care instructions: -Incontinent associated dermatitis (IAD, skin damage associated with incontinence) bilateral (both sides) buttocks; -Dressing status: open to air; -Site assessment: fragile, painful and pink; -Shape/pattern: irregular; -Peri-wound assessment: fragile, painful; -Interventions: cleansed, protective ointment; -Wound status: unchanged; -Non-staged description: partial thickness; -Pressure injury to coccyx: -Dressing status: open to air; -Site assessment: Fragile, painful; -Shape/pattern: Irregular; -Peri-wound assessment: Fragile, painful; -Interventions: cleansed, protective ointment; -Pressure injury Stage: II (partial thickness skin loss, appearing as a shallow, open ulcer with a red or pink wound bed, or as an intact or open/ruptured blister); -Measurements: length 3 cm x width 4 cm; -Margins: Undefined edges; -Wound status: Unchanged. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the facility admission assessment, dated 2/12/25, showed: -admitted from: hospital; -Pain: does the resident report pain currently: no; -Most recent pain level: 8; -Pain plan: -Focus: the resident has acute/chronic pain; -Goal: pain will be minimized with the use of scheduled and/or PRN meds; -Interventions: administer analgesia as ordered, anticipate needs for pain relief, evaluate effectiveness of pain interventions. Review of the POS, showed: -An order dated, 2/13/25: Hydrocodone-Acetaminophen 5 mg/325 mg (a narcotic pain reliever for moderate pain). Take one tablet three times a day for pain; -Documented administered as ordered. -No order for Bactine Spray. Review of the care plan, updated 2/14/25, showed: -Focus: the resident is on pain management therapy; -Goal: free of any discomfort or side effects from pain medication; -Interventions: administer medication as ordered, assess for effectiveness. Ask physician to review medication if side effects persist and monitor for falls. Review of the progress note, dated 2/17/25 at 2:50 P.M., showed: -A medication administration note: hydrocodone 5 mg-325 mg administered for coccyx pain; -No additional notes regarding assessments, treatment or physician notification. Review of the progress note, dated 2/23/25, showed: -At 11:45 A.M., pain to the bottom, barrier cream applied; -At 1:34 P.M., medication note: Hydrocodone 5 mg/325 mg, one tablet administered for buttock pain; -No additional notes or physician notification. (continued on next page)

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 02/06/2025
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)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes, dated 2/28/25, showed: -At 12:44 P.M., a nurse note: pain assessment every shift: buttock pain; -No noted further assessment documented; -At 1:21 P.M., a medication administration note: Hydrocodone administered for buttock pain; -At 5:30 P.M., a late physician visit note: no notification of wound or skin impairment to buttocks. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/2/25, showed: -Cognitively intact; -Diagnosis included: Quadriplegia, Parkinson's disease (a progressive neurodegenerative disorder that affects the brains ability to control body movements), malnutrition, anxiety and depression; -Takes routine pain medication. Review of the progress note, dated 3/20/25, showed: -At 6:37 A.M., a medication administration note: Hydrocodone 5 mg-325 mg administered. Observation and interview on 3/20/25 at 7:30 A.M., showed the resident awake in bed. He/She lay on a standard mattress. CNA D and CNA E assisted the resident onto his/her side and exposed the buttocks. Noted to the sacrum, on the left and right buttock were multiple white gauze pads and foam dressings secured the gauze in place. Blood was noted to various areas of the gauze. CNA D and E said oh my God, (he/she) is bleeding, these are stuck to (him/her), CNA D used a warm soapy washcloth and squeezed the water onto the adhered gauze pads and slowly removed the gauze from the resident's skin. The resident yelled oh God, that hurts and noted to be crying. CNA D and E apologized and continued to remove the bandages. The resident requested the aides spray Bactine (pain relieving over the counter spray) spray and said the spray helps numb it. CNA D cleansed the entire buttock area and sprayed the area with Bactine. Review of the progress notes, showed no pain assessment or physician notification of the increased pain related to wounds. During an interview on 3/20/25 at 1:08 P.M., the DON said the aides should report pain to the nurse immediately. If the resident is expressing pain and tearful, the aides should stop and get the nurse immediately. Aides should not administer over the counter spray pain medications. All medications should be on the POS. The nurse is responsible to provide a pain assessment, document and administer pain medication. If the resident did not have an order for a PRN pain medication, the physician should be contacted to obtain an order. MO00249622 (continued on next page)

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 02/06/2025

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 0697 Level of Harm - Actual harm Residents Affected - Few	MO00250935 44950