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	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Health Care 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse to the Department of Health and Senior Services (DHSS) as required within a two-hour timeframe following a physical altercation between two residents (Residents #1 and #2). The sample was eight. The census was 147. Based on interview and record review, the facility failed to report an allegation of abuse to the Department of Health and Senior Services (DHSS) as required within a two-hour timeframe following a physical altercation between two residents (Residents #1 and #2). The sample was eight. The census was 147. Review of the facility's Abuse and Neglect policy, dated 6/12/24, showed the following:-Purpose: It is the policy of this facility to report all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknow sources and misappropriation of resident property are reported immediately to the Administrator for the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology;-Physical Abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking;-Reporting: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions to determine what changes are needed, if any, to policies and procedures to prevent further occurrences;-Procedure for Response and Reporting Allegations of Abuse, Neglect, and Exploitation:--Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse, neglect, exploitation to any abuse agency hotline without fear of retaliation;-Procedure for Response and Reporting Allegations of Abuse, Neglect, and Exploitation:--When suspicion of abuse, neglect, exploitation or reports of abuse, neglect, exploitation occur the following procedure will be initiated:--The Administrator or designee will:---Refer to the State Operations Manual (SOM) for reporting and utilize the Abuse-Neglect Reporting Decision Tree to assess the particular incident. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/19/26, showed the following:-Severe cognitive impairment;-No moods or behaviors;-Diagnoses included heart failure, cerebral palsy (a group of permanent movement disorders caused by abnormal brain development or damage to the developing brain), and stroke. Review of resident's nurse's note, dated 3/21/26 at 7:21 A.M., showed the resident was in an altercation this morning with his/her roommate, Resident #2. Prior to this event, there had been a verbal disagreement that began to get louder with rising emotions. This nurse physically separated them, moving Resident #1 to the hallway and a safer area. He/She continued to go back to room and (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued the argument. This nurse was called back stating it was a fight. Resident #2 was found standing over Resident #1, yelling. He/She was very upset by this time and demanded to be sent to the hospital for evaluation, also yelling out suicidal ideation. A call was placed to management to inform of issues. The resident was kept near the nurse's station for safety precautions. During an interview on 3/25/26 at 10:15 A.M., the resident said he/she had an altercation with another resident on another floor. The other resident hit him/her and he/she hit him/her back. Review of Resident #2's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-No moods or behaviors;-Diagnoses included high blood pressure, Alzheimer's disease, seizure disorder, schizophrenia (serious mental illness affecting how a person thinks, feels, and behaves), and depression. Review of the resident's medical record, showed no documentation regarding an altercation on with another resident on 3/21/26. During an interview on 3/25/26 at 10:43 A.M., the resident said Resident #1 hit him/her in his/her chest. Review of the DHSS system for reporting alleged violations, showed no documentation of the facility submitting a report regarding a physical altercation between Residents #1 and #2. During an interview on 3/25/26 at 2:00 P.M., Licensed Practical Nurse (LPN) A said another resident came and told him/her there was a fight happening in a room across from him/her. LPN A went to the room shared by Residents #1 and #2. When he/she arrived, LPN A saw Resident #2 was standing over Resident #1, yelling. LPN A asked what happened and each resident said they hit each other. During an interview on 3/26/26 at 12:40 P.M., the Director of Nursing (DON) said she expected the facility's Abuse and Neglect Policy to be followed as written. This would include reporting to the state survey agency in the required timeframe. The DON did not know why this did not happen. During an interview on 3/25/26 at 12:30 P.M., the Administrator said when she initially heard about the incident, she was told there was no physical contact so she did not feel the need to report the incident to DHSS.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse involving a physical altercation between two residents (Residents #1 and #2). The sample was eight. The census was 147. Review of the facility's Abuse and Neglect policy, dated 6/12/24, showed the following:-Purpose: It is the policy of this facility to report all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknow sources and misappropriation of resident property are reported immediately to the Administrator for the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology;-Physical Abuse: Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking;-Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedures for reporting/response as described below:-Procedure for Response and Reporting Allegations of Abuse, Neglect, and Exploitation:--When suspicion of abuse, neglect, exploitation or reports of abuse, neglect, exploitation occur the following procedure will be initiated:--The Licensed Nurse will:---Notify the Administrator or designee;---Monitor and document the resident's condition, including response to medical treatment or nursing interventions;---Document actions taken in the medical record;---Complete an incident report if indicated;---Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. --The Administrator or designee will:---Administrator/Designee will complete an Administrative Investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, any unexpected medical emergency, or when the administrative staff feel uncomfortable in any situation involving resident care or treatment or staff treatment;---The Administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including the facts that prove or disprove the alleged situation occurred, the plan of correction or action by the administrative staff, all statement attached from resident and staff involved and any training or education that the administration feels needs to be provided to staff or residents to ensure education had been provided to prevent future similar situations. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/19/26, showed the following:-Severe cognitive impairment;-No moods or behaviors;-Diagnoses included heart failure, cerebral palsy (a group of permanent movement disorders caused by abnormal brain development or damage to the developing brain), and stroke. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding an altercation with another resident on 3/21/26. Review of resident's nurse's note, dated 3/21/26 at 7:21 A.M., showed the resident was in an altercation this morning with his/her roommate, Resident #2. Prior to this event, there had been a verbal disagreement that began to get louder with rising emotions. This nurse physically separated them, moving Resident #1 to the hallway and a safer area. He/She continued to go back to room and continued the argument. This nurse was called back stating it was a fight. Resident #2 was found standing over Resident #1, yelling. He/She was very upset by this time and demanded to be sent to the hospital for evaluation, also yelling out suicidal ideation. A call was placed to management to (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inform of issues. The resident was kept near the nurse's station for safety precautions. During an interview on 3/25/26 at 10:15 A.M., the resident said he/she had an altercation with another resident on another floor. The other resident hit him/her and he/she hit him/her back. Review of Resident #2's quarterly MDS, dated [DATE], showed the following:-No cognitive impairment;-No moods or behaviors;-Diagnoses included high blood pressure, Alzheimer's disease, seizure disorder, schizophrenia (serious mental illness affecting how a person thinks, feels, and behaves), and depression. Review of the resident's care plan, in use at the time of survey, showed no documentation regarding an altercation with another resident on 3/21/26. Review of the resident's medical record, showed no documentation regarding an altercation on with another resident on 3/21/26. During an interview on 3/25/26 at 10:43 A.M., the resident said Resident #1 hit him/her in his/her chest. Review of Resident #8's comprehensive MDS, dated [DATE], showed: -Cognitively intact;-Diagnoses included anxiety and schizophrenia. During an interview on 3/26/26 at 11:24 A.M., Resident #8 said he/she woke up and heard two residents arguing in the hall. He/She went to get Licensed Practical Nurse (LPN) A. He/She did not see anyone get hit. Before today, no one asked him/her about the incident. During an interview on 3/25/26 at 2:00 P.M., LPN A said Resident #8 came and told him/her there was a fight happening in a room across from him/her. LPN A went to the room shared by Residents #1 and #2. When he/she arrived, LPN A saw Resident #2 was standing over Resident #1, yelling. LPN A asked what happened and each resident said they hit each other. LPN A did not see either resident hit each other. He/She separated the residents and contacted the on-call supervisor, the Assistant Director of Nursing (ADON). LPN A was not asked to write a statement about the altercation. He/She thought he/she documented the incident in the medical records for both residents. During an interview on 3/26/26 at 8:35 A.M., the ADON said he/she was the on-call supervisor when LPN A notified him/her of the altercation between Residents #1 and #2. LPN A never said the residents hit each other. LPN A only said the residents were in an argument. Had the ADON known there was a physical altercation, he/she would have reported it to the Administrator immediately. During an interview on 3/26/26 at 12:40 P.M., the Director of Nursing (DON) said she expected the facility's Abuse and Neglect Policy to be followed as written. This would include giving accurate information regarding the incident. This will allow a thorough investigation to happen, which would include gathering statements from residents and staff. The DON did not know why this did not happen. During an interview on 3/25/26 at 12:30 P.M., the Administrator said she did not interview Resident #1 because the resident was not in the facility. She obtained interviews from other people but did not document them. She should have gotten statements from all involved parties, and should have conducted a thorough investigation, per the facility's policy. 29602492964554

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. This had the potential to affect all residents of the facility. The sample was 8. The census was 147.Review of the facility's Sufficient Staffing Policy, dated February 2023, showed the following:-Purpose: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment;-Policy:-The facility is required to provide licensed nursing staff 24 hours a day, 7 days a week;-Except when waived, the facility must use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week. Review of the facility's staffing sheets for March 2026, showed the following:-On 3/1/26, no RN scheduled;-On 3/7/26, no RN scheduled;-On 3/9/26, no RN scheduled;-On 3/14/26 through 3/17/26, no RN scheduled;-On 3/21/26 and 3/22/26, no RN scheduled;-On 3/25/25, no RN scheduled. During an interview on 3/26/26 at 12:40 P.M., the Director of Nursing (DON) said she was the on-call person for the days in which no RN was scheduled and she thought that would count as the facility's RN coverage. The DON said she was in the building at times on those days, but not eight hours. During an interview on 3/26/26 at 12:40 P.M., the Administrator said she was aware there needed to be an RN scheduled for at least eight hours a day, seven days a week. The DON is salaried so she does not clock in for when on duty. 2800874