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	04/24/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect by failing to ensure staff communicated with residents in an appropriate and respectful manner for three residents (Residents #12, #71, and #73). The facility also failed to ensure privacy was provided for one resident during care (Resident #86). In addition, the facility failed to ensure staff followed the facility's cell phone policy, while providing care to one resident (Resident #133). The sample size was 33. The census was 149. Review of the facility's promoting resident dignity policy, dated 9/21/25, showed:-Purpose: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life by recognizing each resident's individuality;-Procedure: Every resident has a right to be treated with dignity and respect. All staff will speak to and treat all residents with dignity and respect. Speak respectfully to residents; avoid discussions about residents that may be overheard. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused and resident centered. Review of the facility's electronic devices in the workplace policy, dated 4/25/25, showed:-Purpose: To ensure that all electronic devices used at work are used for the benefit of patient care and their use does not violate the privacy of our residents;-The use of electronic devices while at work is strictly prohibited, unless the device is being used for conducting facility business and to perform your daily assignments. 1. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/8/26, showed:-Diagnoses included anorexia, bipolar disorder (mood disorder that causes mood swings), post-traumatic stress disorder (PTSD), and major depressive disorder;-Cognitively intact. During an interview on 4/19/26 at 9:22 A.M., the resident said staff talked down to him/her and the residents on his/her hallway. He/She felt like staff did not treat him/her like an adult. 2. Review of Resident #71's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic kidney disease, disorganized schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), bipolar disorder, anxiety, and major depressive disorder;-Cognitively intact. Observation on 4/20/26 at 12:29 P.M., showed the resident came out of his/her room to the nurse's station. He/She told Certified Nursing Assistant (CNA) T that he/she was still hungry after eating lunch. CNA T told the resident he/she would call dietary to bring him/her more food. Dietary Aide II came to the nurse's station and in front of the resident, told CNA B that he/she was too busy to get the resident food, and CNA T needed to go down to the kitchen and get the food himself/herself. The resident started to cry and said I'm hungry. Why can't you bring me food? Dietary Aide II ignored the resident and walked back off the hallway. During an interview on 4/20/26 at 12:42 P.M., the resident said the interaction between CNA T and Dietary Aide II made him/her feel sad and like he/she was a burden to staff for asking for food. During an interview on 4/24/26 at 7:29 A.M., the Regional Certified Dietary Manager said if a resident told a staff member they were hungry, dietary staff should get the resident food. If the staff member was busy, they (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have found another staff member to bring the resident food. He expected staff to speak to residents in a dignified manner. During an interview on 4/24/26 at 9:37 A.M., Licensed Practical Nurse (LPN) N said it was not appropriate to talk in front of the residents in a way that made it sound like they could not be helped. He/She said staff should speak in a dignified manner to the residents. During an interview on 4/24/26 at 8:40 A.M., the Nurse Manager said there was a dignity issue amongst facility staff all over the building. He/She expected staff to speak in private and not in front of the resident if they had time concerns or felt like they could not assist the resident. She expected staff to speak to and in front of residents in a dignified manner. 3. Review of Resident #73's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic kidney disease, schizophrenia, bipolar disorder, anxiety, and major depressive disorder;-Cognitively intact. Observation on 4/21/26 at 9:27 A.M., showed CNA B in the resident's room standing right inside the door. Both the resident and CNA B were screaming at each other. LPN D walked up to the doorway and told CNA B to stop screaming at the resident. CNA B said to LPN D the resident was not going to speak to him/her like that and then left the resident's room and walked down the hallway towards the nurse's station. During an interview on 4/21/26 at 9:33 A.M., CNA B said he/she went into the resident's room to ask him/her a question, and the resident started to yell at him/her. CNA B said he/she yelled right back at the resident to match the resident's energy. He/She knew he/she shouldn't speak that way to the residents. During an interview on 4/24/26 at 4:01 P.M., the Administrator and Director of Nursing (DON) said they expected staff to speak to residents in a dignified manner. They said it was not appropriate for staff to scream at residents. 4. Review of Resident #86's quarterly MDS, dated [DATE], showed:-Diagnoses included Alzheimer's disease, dementia, muscle weakness/wasting, and chronic kidney disease;-Severe cognitive impairment. Observation on 4/20/26 at 7:45 A.M., showed the resident sitting on the edge of his/her bed. The door to the resident's room was open and the privacy curtain was tucked away. CNA M stood in front of the resident and changed the resident from pajamas to clothing. The resident's breasts were exposed to the hallway. During an interview on 4/24/26 at 10:23 A.M., CNA M said he/she was in a hurry to get residents up, because the night shift had not gotten any of the residents up. He/She should have closed the resident's door before getting the resident undressed to ensure the resident's dignity and privacy were upheld. During an interview on 4/24/26 at 4:01 P.M., the DON and Administrator said before a resident was changed, staff should ensure the bedroom door was closed and the privacy curtain was in place. 5. Observation on 4/21/26 at 8:41 A.M., showed Certified Medication Technician (CMT) G at the medication cart outside of the first-floor dining room. CMT G was heard talking while standing at the medication cart. He/She wore an earpiece in his/her ear. CMT G stood at the medication cart, administering medications to residents and was heard from approximately 20 feet away. He/She continued to have a conversation and continued to repeat, I need my money. CMT G administered medications to a resident in room [ROOM NUMBER] and was heard continuing the conversation on the phone from inside the resident's room. Observation on 4/21/26 at 8:46 A.M., showed a sign posted on the wall on the 100 South unit. The sign read, no Bluetooth zone. Better care starts with full attention. Reminder no phones in residential areas. Review of Resident #133's quarterly MDS, dated [DATE], showed:-Diagnoses included heart failure, anxiety, and depression;-Cognitively intact. During an interview on 4/21/26 at 1:03 P.M., Resident #133 said he/she resided on 100 South. The facility tried to put up a sign regarding cell phone use, but staff did not care. He/She heard a CMT on the phone this morning and he/she was fussing while on the phone. 6. Observation on 4/22/26 at approximately 1:30 P.M., showed CNA CC sat sitting at the one main nurses' station laughing and looking at his/her cell phone during a video call. A voice from the video call could be heard. Residents were observed walking past the nurses' station. 7. During an interview on 4/21/26 at 1:03 P.M., ten residents from the resident council confirmed they saw staff with an earpiece or Air pods, talking on the phone. It was every day and weekends. Staff continued to talk on the phone and ignored the residents. During an interview on 4/24/26 at 3:38 P.M., the Administrator and DON said expected residents to be treated in a dignified (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manner. They expected staff to refrain from using the telephone while assisting residents and passing medications. The Administrator said they were not supposed to be on the phone. It was an ongoing issue. There was a policy. 1619729

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were allowed to exercise their right to choose their attending physician when the facility discontinued services with Physician RR and failed to permit Physician RR to continue providing care within the facility, resulting in residents being required to transition to a different physician for two residents (Residents #133 and #139). The sample size was 33. The census was 149. Review of the facility's undated admission Agreement, showed:-Resident rights: Facility has delivered, and Resident acknowledges receipt of a document entitled "Nursing Home Resident Rights that describes Resident's rights at Facility. Resident also acknowledges that Facility has orally explained these rights in terms Resident can reasonably be expected to understand. The rights of Resident do not include any proprietary, legal or equitable interest in the properties of Facility;-Selection of Healthcare Professionals by Resident: Resident may select, or have selected on his/her behalf, qualified healthcare professionals who conform to Facility's policies and rules and applicable laws and regulations. Resident must have, select, or have chosen on his/her behalf a personal physician licensed in Missouri who is responsible for resident's total care and will be available, or whose agent will be available, at all times for notification of significant changes in Resident's clinical condition. Facility may require that the healthcare professional be credentialed by Facility. Resident agrees that any expense for such services shall be borne by resident. 1. Review of Resident #133's quarterly Minimum Data Set (MDS , a federally mandated assessment instrument completed by facility staff), dated 3/8/26, showed the following:-Cognitively intact;-Diagnoses included anemia, heart failure, high blood pressure, stroke, anxiety, depression, and psychotic disorder. Review of the resident's face sheet, showed:-Original admission date of 8/3/12;-Physician DD was documented as the resident's primary physician;-Nurse Practitioner SS was documented as alternate physician;-Resident is his/her own responsible party. During an interview on 4/22/26 at 1:20 P.M., the resident said he/she had received the letter from the facility regarding Physician RR. Other residents were upset, including Resident #133 because they had Physician RR for so many years. He/She heard the nursing staff discussing Physician RR and the only complaint he/she heard was that Physician RR did not return calls fast enough. Review of facility's physician letter, dated 4/10/26, and signed by the administrator, showed:-Physician RR continues to fail to sign orders, complete Medicare certification, and timely enter progress notes;-The facility has asked residents under his/her care to transition to alternative physicians;-The admission Agreement provides that, if a physician fails or refuses to meet applicable statutory or regulatory requirements, the facility may assist the resident in selecting another physician to ensure the resident's care needs are met. During an interview on 4/23/26 at 12:47 P.M., Resident #133 said staff came around with a letter. He/She asked what happened to Physician RR, but he/she was ignored. He/She asked social services, and he/she said it was Physician DD now. 2. Review of Resident #139's face sheet, showed:-Original admission date of 11/24/24;-Physician DD was documented as the resident's primary physician;-Resident is his/her own responsible party. Review of Resident #139's quarterly assessment MDS dated [DATE], showed the following:-Cognitively intact;-Diagnoses included high blood pressure, anxiety, depression, schizophrenia (a chronic severe brain disorder characterized by symptoms like hallucinations, delusions and disorganized thinking), post-traumatic stress disorder, and asthma. During an interview on 4/24/26 at 2:25 P.M., Resident #139 said quite a few residents wanted to keep Physician RR. They automatically enrolled them to see Physician DD whether they wanted to or not. The resident did not want to put up a fight. If Physician RR returned, that would be great. He/She had a rapport with Nurse Practitioner SS for nine years. 3. During a group interview on 4/21/26 at 1:03 P.M., nine residents said they dropped Physician RR about a month ago. They passed a sheet to residents that said they were not using Physician RR, and they had a new doctor. 4. During an interview on 4/23/26 at 11:02 A.M., the Director of Nursing (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON) said to his/her understanding, Physician RR did not sign orders or return phone call. The DON had been working at the facility since October or November 2025, and he/she had only seen Physician RR in the facility once. The DON was asked if he/she could provide specific examples of how it impacted resident care. To his/her knowledge, care was not delayed. They could not reach Physician RR, so they contacted Nurse Practitioner SS, who worked with Physician RR. Nurse Practitioner SS was easier to reach. Physician RR was no longer the facility's primary physician as of last month. 5. During an interview on 4/23/26 at 12:33 P.M., Licensed Practical Nurse (LPN) E said Resident #133 and Resident #139 wanted to keep Physician RR. There was a third resident that loved Physician RR. They met the new physician, but they had a rapport with Physician RR. 6. During an interview on 4/24/26 at 10:16 A.M., the DON said there were no residents that expressed feelings about not having Physician RR anymore. Physician RR was difficult to get ahold of and get in contact with. It was easier to talk to Nurse Practitioner SS. 7. During an interview on 4/24/26 at 3:38 P.M., the Administrator said the residents received 30 days' notices that the primary physician was changed. Residents were able to continue to see Physician RR, but not in the facility. They had to go to Physician RR's office. She would expect the residents to choose their own physician and they could choose to see Physician RR, but outside the facility. The only resident that wanted to continue to see Physician RR was Resident #133. He/he was given the option to see Physician RR, just not at the facility. Intake: 2797362

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a clean and homelike environment by failing to ensure the 300 south hallway shower room was clean, the 300 south sitting room had a broken television removed, the 200 hallway was free from odors and the floors were clean, the 300 south bathrooms had working soap dispensers and towel holders, and room [ROOM NUMBER] had broken floor tiles and a television on the floor removed. The sample size was 33. The census was 149. Review of the facility's housekeeping deep cleaning policy, dated 6/29/23, showed:-Purpose: To ensure all rooms are clean;-Policy: Deep cleaning is to be completed as scheduled. This includes complete pull-outs of furniture in rooms, wall cleaning, floor cleaning (scrubbing and waxing included), restrooms to be cleaned and disinfected, cob webs removed, beds and rails to be cleaned, sprinkler heads to be cleaned, light covers to be clean and free of bugs, over -bed light covers to be cleaned and free of bugs, sink clean, windows to be cleaned and ensure no spider webs, drapes and curtains to be cleaned (including privacy curtains), call lights to be clean and free from dust/dirt build-up, floors at closets and doorways are to be free from wax/dirt build up, etc.;-Daily Cleaning: Pick up all trash and put into trash can and empty. Dust mop or sweep floor. Surfaces are to be cleaned including wall smudges, light and call light and side tables, head/ foot board/side rails of beds, windows. Clean bathroom using the same cleanser/disinfectant wall smudges, lights, and call switches, and support rails. Use Honey Bowl to clean inside, outside toilet tank, seat and bowl. Clean shower rooms inside the shower, around the shower, and the base boards in the room. 1. Observation of the 300 south hallway shower room, showed:-On 4/20/26 at 7:37 A.M., the toilet had brown and yellow matter on it. The bathtub was dirty with hair. The floor was dirty with debris in various areas;-On 4/20/26 at 12:13 P.M., the toilet had brown and yellow matter on it. The bathtub was dirty with hair;-On 4/21/26 at 5:31 A.M., the toilet had brown and yellow matter on it. The bathtub was dirty with hair. During an interview on 4/24/26 at 11:30 A.M., Housekeeper Q said the bathrooms were cleaned twice a day and as needed. He/She said the toilet, bathtub/shower, and floors were to be cleaned. During an interview on 4/24/26 at 1:16 P.M., Certified Nursing Assistant (CNA) B said since the new ownership took over the facility, the housekeeping staff hours had been cut. He/She said the bathrooms were not being cleaned as often as they should be. During an interview on 4/24/26 at 4:05 P.M., the Administrator said housekeeping staff were responsible for cleaning bathrooms and resident rooms. She expected housekeeping staff to clean the 300 south shower room once a day and as needed. 2. Observation of the 300 south hallway sitting room, showed:-On 4/19/26 at 8:49 A.M., the television on the wall was smashed with a cracked screen; -On 4/21/26 at 10:18 A.M., the television on the wall was smashed with a cracked screen. During an interview on 4/24/26 at 10:19 A.M., the Maintenance Director said he was aware of the broken television in the 300 south hallway sitting room. He would expect for the television to be removed and replaced. During an interview on 4/24/26 at 4:05 P.M., the Administrator said maintenance staff was responsible for fixing broken appliances. If they were unable to fix the appliance, she expected them to come to her so she could order a new appliance. She expected for the television on the 300 south hallway to be taken down and replaced. She said the television had been broken since 2/1/26 when a resident threw a chair at it. 3. Observation of the 200 hallway, showed:-On 4/20/26 at 10:53 A.M., a strong urine odor and sticky floors in the main hallway and sitting room;-On 4/21/26 at 5:13 A.M., a strong urine odor and sticky floors in the main hallway and sitting room;-On 4/23/26 at 8:27 A.M., a strong urine odor and sticky floors in the main hallway and sitting room. During an interview on 4/24/26 at 11:30 A.M., Housekeeper Q said floors and the sitting room on the 200 hallway should be cleaned and free from odors. He/she said the housekeeping department was short staffed so the sitting room was only cleaned once a day. He/She said there were residents on the 200 hallway that went to the bathroom in the sitting room instead of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathroom. During an interview on 4/24/26 at 4:05 P.M., the Administrator said housekeeping staff was responsible for cleaning the building. Nursing staff cleaned bodily fluids and then housekeeping staff came behind them to sanitize the area. She expected the 200 hallway to be free from odors. She expected the floor to be clean and not sticky. She said there were residents on the 200 hallway that went to the bathroom in the sitting room instead of the bathroom so the urine odor could be hard to get rid of. 4. Observations on 4/19/26 at 9:43 A.M., 4/20/26 7:44 A.M., and 4/24/26 at 10:39 A.M., showed on 300 South, the first shower room had a detached paper towel and soap dispenser. There were no paper towels or soap bottles for residents to wash their hands. During an interview on 4/24/26 at 10:39 A.M., Maintenance Worker FF said housekeeping was responsible for the soap and paper towel holders. The residents ripped them off the wall. The front desk had a plan to keep them stocked. 5. Observations on 4/19/26 at 9:48 A.M., 4/20/2026 7:47 A.M., and 4/24/26 at 10:39 A.M., showed room [ROOM NUMBER] had four tiles removed, visible from the doorway and another tile removed from in front of the bed. The removed tiles were laid out on the floor. A television was on the floor next to the window with a cord in the walkway. 6. During an interview on 4/24/26 at 10:58 A.M., the Maintenance Director said the tiles removed and left on the floor in room [ROOM NUMBER] did not make it a homelike environment. He needed some adhesive glue to put the tiles back on the floor. He was not informed or saw a work order for the soap dispenser or paper towel holder removed in the first shower room. He was unaware the second shower room had holes in the wall where the toilet paper holder used to be. During an interview on 4/10/26 at 12:32 P.M., the Administrator said maintenance was responsible for fixing things that were broken. Housekeeping staff was responsible for cleaning the facility. The Administrator said she expected the removed tiles to be picked up off the floor and removed from residents' area. Loose tiles could cause other residents to trip or other residents to throw them. She expected the broken paper towel holder and soap dispenser to be fixed. The second shower room with the toilet paper holder missing should have been fixed, and the holes patched. 2983889

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three residents (Residents #100, #49, and #111) were free from resident-to-resident abuse. Resident #1 had a documented history of behavior problems. On 4/14/26, Resident #1 displayed changes in behavior and hit Resident #100. The altercation resulted in injuries to Resident #1's face. On 4/17/26, Resident #1 hit Resident #49 and a physical altercation later took place, resulting in Resident #1 sustaining fractured ribs and Resident #49 sustaining a fractured hand. Resident #1 also hit Resident #111 in the face with a closed fist, resulting in Resident #111 experiencing pain. The sample was 333. The census was 149. Review of the facility's Abuse and Neglect policy, reviewed 6/12/24, showed:-Abuse: 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. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well?being. 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 includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Physical abuse also includes corporal punishment, which is physical punishment used as a means to correct or control behavior;-Policy: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences;-Training: New employees will be educated by the department manager, or designee, on issues related to abuse prohibition practices and abuse reporting requirements during initial orientation. Annual education and training will be provided to all existing employees. Front line supervisors will provide education as situations arise;-Prevention: The facility will provide resident, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution, and will provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur;-Identification: The facility will identify events, occurrences, patterns and trends that may constitute mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property as defined above;-Investigation: The facility will investigate all allegations and types of incidents as listed above in accordance to facility procedure for reporting/response as described below;-Protection: The facility will protect residents from harm during an investigation;-The facility will identify and correct by providing interventions in which abuse, neglect or misappropriation of resident property is more likely to occur. This will include; assessment of the physical environment, which may make abuse or neglect more likely to occur, such as more secluded areas in the facility, the deployment of staff on each shift in sufficient numbers to meet the resident's needs and that the staff are knowledgeable of resident care needs. Supervisors should identify inappropriate behaviors such as; derogatory language and neglectful care. Prevention will also include assessment care planning and monitoring of residents with needs or behaviors which may lead to conflict or neglect. The facility will identify events, patterns and trends that may constitute abuse and investigate (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	thoroughly, notifying the Administrator and the proper authorities. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/15/26, showed:-Diagnoses included stroke, heart disease, heart failure, hypertension (high blood pressure), kidney failure, pneumonia, diabetes, hyperlipidemia (high cholesterol), traumatic brain injury, schizophrenia (serious mental illness that affects how a person thinks, and behaves), asthma, and respiratory failure;-Severe cognitive impairment;-No verbal or physical behaviors exhibited;-Use of walker and wheelchair;-Received antipsychotic and antidepressant medication in the last seven days. Review of the resident's care plan, in use during survey, showed:-Problem: Resident has a history of behavior problems including delusional thoughts and accusatory behaviors. Has a history of accursing staff and peers of choking/hurting him/her. Power of Attorney (POA) confirmed this history and believes a family member that visits triggers this behavior. On 12/16/25, resident throws him/herself on the floor as a behavior;--Interventions:---Administer medications as ordered;---Monitor/document for side effects and effectiveness;---Anticipate and meet his/her needs;---Educate resident/family/caregiver on successful coping and interaction strategies;---Encourage resident to express feelings appropriately;---Explain/reinforce why behavior is inappropriate and/or unacceptable;-Problem: Resident is at risk for physical aggression related to diagnosis and history;--Interventions:---Assess and anticipate resident's needs: food, thirst, toileting need, comfort level, body positioning, and pain;---Communication: Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encouraging seeking out of staff member when agitated. Review of the resident's lab results, dated 4/13/26, showed:-Collection date: 4/9/26;-Received date: 4/10/26;-Reported date: 4/13/26 at 3:19 P.M.;-Susceptibility: Escherichia coli (E. coli);--Colony Count: 50,000-99,000 (indicates a significant urinary tract infection (UTI)). Review of the resident's progress notes, showed:-On 4/14/26 at 9:00 A.M., new order for Augmentin (amoxicillin, an antibiotic) 875-125 milligram (mg) twice a day for five days, for UTI, all appropriate parties notified;-On 4/15/26 at 10:23 P.M., resident in bed, no signs of acute distress noted. Remains on antibiotic for UTI without adverse side effects noted. Able to make needs known. Refused skin assessment two times. This nurse observed a raised area to right side of forehead, an abrasion to the bridge of the nose and swelling noted to the right side of face, right cheek and eye. Resident would not allow a better assessment. Plan of care ongoing;-On 4/16/26 at 10:55 A.M., resident remains on antibiotic therapy for infection. No adverse reactions noted. Resident afebrile (no fever), no pain or discomfort noted. Fluids encouraged;-No documentation of increased behaviors before 4/9/26;-No documentation of a reason/rationale for urinalysis obtained on 4/9/26;-No documentation of an incident or physical altercation on 4/14/26. Review of Resident #100's quarterly MDS, dated [DATE], showed:-Diagnoses included anemia, heart disease, heart failure, high blood pressure, kidney failure, and hyperkalemia (high potassium);-Cognitively intact;-No verbal or physical behaviors exhibited;-Use of a walker and wheelchair. Review of the resident's care plan, in use during survey, showed:-Problem: On 4/14/26, resident was the recipient of physical aggression from another resident;--Interventions: Resident assessed for pain and injury. Skin assessment performed. Review of the resident's psychosocial post-incident impact note, dated 4/15/26 at 2:09 P.M., showed no documentation of what type of incident occurred. During an interview on 4/22/26 at 6:08 P.M., Resident #100 said he/she was in the hall with his/her roommate when Resident #1 came up. Resident #1 stood up and knocked Resident #100's hat off his/her head. Resident #100 did not touch Resident #1. Staff came running down before he/she could do anything. Review of the facility's investigation, showed:-Date and approximate time of incident: 4/14/26 at 4:00 P.M.;-Type of incident: Physical aggression not involving head;-Persons involved in the incident: Resident #1 and Resident #100;-Witness: Certified Medication Technician (CMT) Y;-Was this investigation completed for a behavior emergency: Yes;-Investigative narrative note: Resident #100 was trying to get in his/her room and Resident #1 was trying to get in the room. Resident #1 began (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	hitting Resident #100; -Conclusion/outcome for investigation: Resident #1 was the aggressor and was sent out for evaluation;-Care plan changes and interventions: Resident #1 assessed for pain and injury, ensure protective oversight;-Was there a physical altercation: Yes;-Has the resident had any ongoing concerns: Yes;-In conclusion of this investigation, it is reasonable to believe that this injury was not caused by abuse or neglect and was not preventable and is not previous ongoing problem that the facility could have foreseen due to prior history: Yes. Review of CMT Y's interview from the facility's investigation, dated 4/14/26, showed CMT Y saw Resident #1 fighting. Resident #100 was trying to get into his/her room and Resident #1 was sitting in front of the room. They were fighting. Resident #1 was standing up, hitting Resident #100. Certified Nurse Aide (CNA) H broke it up. Review of CNA H's interview from the facility's investigation, dated 4/14/26, showed CNA H saw Resident #1 stand up and punch Resident #100 several times. CNA H ran up behind and grabbed Resident #1. Not sure what led to the situation of Resident #1 hitting him/her. Review of Resident #1's psychosocial post-incident impact note from the facility's investigation, dated 4/15/26 at 2:05 P.M., showed:-Resident was the aggressor in an incident;-Why were you trying to hurt yourself or others: I was angry;-What coping skills have you identified that you utilize and do you feel they are working: I'm just not gonna say nothing no more;-What do you feel we can do or change to allow your coping skills to be more effective: I do not know;-What do you feel you could have done differently in the situation: Not fought with him/her;-Do you feel safe: Yes;-Do you feel you need to talk to someone: No;-Can you identify at least one staff member that you feel safe with to share your thoughts/feels with? Who: No. 2. Review of Resident #1's care plan, updated on 4/15/26, showed:-Problem: On 4/14/26, resident engaged in physical aggression with another resident due to other resident blocking the door;--Interventions: Resident assessed for pain and injury. Skin assessment performed;-Problem: On 4/17/26, resident engaged in physical aggression with two other residents due to believing that another resident killed his/her baby;--Interventions: Assessed for pain and injury. Skin assessment performed. Resident to emergency room for change in mental status;-Problem: Resident engaged in physical aggression with two other residents;--Interventions: Resident will voice feelings with staff. Staff will continue to redirect resident and encourage positive behaviors. Staff will identify triggers to reduce physically aggressive episodes;-The care plan did not identify what specific triggers could potentially increase physically aggressive episodes and did not identify specific strategies for staff to use when redirecting the resident. Review of the resident's progress notes, showed:-On 4/17/26 at 7:09 P.M., resident in hallway striking other residents. Resident verbally aggressive with staff and residents, refusing vital signs and assessment. Resident being sent to emergency room for change in mental status per Director of Nursing (DON);-On 4/17/26 at 7:58 P.M., a psychosocial post-incident impact note. Resident was the aggressor in an incident. Resident was asked do you have any other needs or items that you would like addressed: I want out of here;-On 4/17/26 at 8:28 P.M., skin check. Skin warm and dry, skin color within normal limit, and turgor is normal;--Skin issue: New skin issue;--Location: Forehead;--Laterality/orientation: Right;--Additional location information: Above eye;--Issue type: Bruising;--Wound acquired In-house;--Exact date: 4/14/26;--Measurements: Not document as part of this assessment;--Reason measurements not documented as part of this assessment: Bruising without opening;-On 4/17/26 at 9:38 P.M., physician made aware of resident behavior and transfer to emergency room;-On 4/18/26 at 1:57 A.M., resident transferred to emergency room per stretcher on ambulance for evaluation and treatment. Review of the resident's hospital record, showed:-admission date: 4/18/26;-History of present illness: Resident presenting with altered mental status (AMS) and bruising to his/face reportedly after altercation at Skilled Nursing Facility. Patient desaturated (drop in blood oxygen level) in the emergency department to 84% (normal 95% to 100%) on room air and Computed Tomography Pulmonary Embolism (CTPE) was obtained with findings of acute left posterior 10th and 11th rib fractures;-Fracture of multiple ribs of left side: Left posterior 10th and 11th rib (bottom-back area of the ribcage, just above the waist) fractures;--Minimally displaced on imaging;--admitted to Intensive Care Unit (ICU) for oxygen (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	requirement/rib score (predicts pulmonary outcome from rib fracture);-discharge date : [DATE]. Review of Resident #49's quarterly MDS, dated [DATE], showed:-Diagnoses included coronary artery disease, high blood pressure, non-Alzheimer's dementia, seizure disorder, anxiety;-No cognitive impairment;-No verbal or physical behaviors exhibited;-Use of wheelchair. Review of the resident's progress notes, showed:-On 4/18/26 at 6:14 P.M., staff documented the resident has complaint of pain to right hand, swelling noted, physician notified. New order for x-ray to right hand. All appropriate parties notified;-No documentation of cause or events that led to the resident's complaints of hand pain and swelling. Review of the resident's physician order summary (POS), dated April 2026, showed an order, dated 4/18/26, for imaging for right hand, two views, one time. Sent for imaging on 4/18/26. Review of the resident's x-ray results, dated 4/19/26, showed:-Examination date: 4/18/26;-Reported date: 4/19/26;-Procedure: Right hand, two view;-Findings: Images of the right hand are submitted. There is an acute fracture of the neck of the fourth metacarpal (the bone in the hand connecting the ring finger to the wrist) with approximately 50 degrees of volar angulation (fracture deformity where the distal bone fragment tilts toward the palm side of the hand) and mild displacement. There is associated soft tissue swelling;-Conclusion: Acute fracture of the right fourth metacarpal neck. Review of Resident #49's interview from the facility's investigation, dated 4/18/26, showed Resident #1 came into their room and closed the door behind him/her. Resident #49 stated that he/she was attempting to leave out. Resident #49 said, What's up, to Resident #1. Resident #1 stated, What can be up. Resident #1 proceeded to grab the wheelchair pedal and hit Resident #49 on his/her right hand. Resident #49 then got up and pushed Resident #1 over his/her bed and a few other items laying around. Resident #49 then left the room and proceeded down the hallway. Once Resident #49 came back up to the floor and passed Resident #1 again, Resident #1 attempted to swing on him/her again and he/she ducked the swing. Review of the resident's care plan, updated 4/19/26, showed:-Problem: On 4/17/26, resident was the recipient of physical aggression by another resident;--Interventions: Resident assessed for pain and injury. Skin assessment performed. During an interview on 4/24/26 at 8:34 A.M., Resident #49 said he/she was roommates with Resident #1, but not anymore. The first incident happened when Resident #1 swung on him/her and he/she threw the resident on the ground. Resident #1 was standing at the time in between the bed and dresser. He/She even tried it with the resident down the hall. When Resident #1 returned to the room, Resident #49 was sitting on the bed. Resident #1 came in and hit him/her with a wheelchair foot pedal on his/her right hand. After Resident #1 hit him/her with the foot pedal, Resident #49 jumped up and punched Resident #1. Resident #1 was laughing and said, I'll be back. No staff entered the room. Resident #49 reported it to staff and they did not come when the incident occurred. Review of Resident #111's modified quarterly MDS, dated [DATE], showed:-No cognitive impairment;-Diagnoses included non-traumatic spinal cord dysfunction, anemia, high blood pressure, neurogenic bladder (lack of bladder control), hyperlipidemia, malnutrition, depression,-No verbal or physical behaviors exhibited;-Use of wheelchair. Review of the resident's progress notes, showed:-On 4/22/26 at 7:34 A.M., psychosocial post-incident impact note. Resident was involved in an incident as the victim. The note did not include a description of the incident. Review of the resident's POS, dated April 2026, showed an order, dated 4/18/26, for imaging to skull - complete. Sent for imaging on 4/18/26. Review of the resident's x-ray results, dated 4/18/26, showed:-Examination date: 4/18/26;-Reported date: 4/18/26;-Procedure: Skull complete, minimum four views;-Findings: The bony calvarium (top part of the skull) appears intact, with no fracture identified;-Conclusion: Unmarkable skull. Review of Resident #111's interview from the facility's investigation, undated, showed per Resident #111, when he/she got off the elevator, Resident #1 said he/she killed his/her kid or baby and swung on him/her. Per Resident #111, he/she did not know what he/she was talking about. During an interview on 4/24/26 at 9:23 A.M., Resident #111 said the fight was out in the hallway. Resident #1 punched him/her on the left side of the face with a closed fist. It still hurts. Review of the facility's investigation, showed:-Date and approximate time of incident: 4/17/26 at 3:00 P.M.;-Type of incident: Physical aggression not involving (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	head;-Persons involved in the incident: Resident #1 aggressor. Resident #49 and #111 victims;-Witness: Resident witness and CNA X;-Was this investigation completed for a behavior emergency: Yes;-Investigative narrative note: Resident #1 thought that Resident #111 killed his/her baby and hit him/her in the head. No injuries noted. During our investigation and getting statements, we found out that Resident #1 had hit Resident #49 in the hand with a wheelchair pedal in their room. This was unwitnessed. Assessments completed, family, and physician notified. Resident #1 sent to the hospital. X-rays for Resident #49 ordered and awaiting results;-Conclusion/outcome for investigation: Resident #1 was the aggressor and hit both residents unprovoked. It is noted that Resident #1 has a UTI and is on antibiotics for it;-Care plan changes and interventions: Care plan updated, room changes when Resident #1 returns to the facility;-Was there a physical altercation: Yes;-Has the resident had any ongoing concerns: Yes;-Steps taken to prevent further occurrence of the issue: Room/unit moves;-In conclusion of this investigation, it is reasonable to believe that this injury was not caused by abuse or neglect and was not preventable and is not previous ongoing problem that the facility could have foreseen due to prior history: Yes. Review of CNA X's interview from the facility's investigation, undated, showed CNA X said he/she helped his/her co-worker stop Resident #1 from jumping on Resident #111. As they were escorting Resident #1 down the hall, Resident #49 hit him/her in the head. Resident #49 told Resident #1 he/she was going to get him/her when he/she comes back in the room that night. Review of Resident #1's witness interview, dated 4/18/26, showed Resident #1 said Resident #111 got off the elevator and went past Resident #1 and Resident #1 swung on Resident #111 for no reason at all, hitting him/her in the head. Resident witness screamed for help and the aides came and stood in between them separating them. They escorted Resident #1 to 1 South nurse's station to watch him/her. While taking Resident #1 to the nurse's station, Resident #49 was rolling by and Resident #1 started hitting Resident #49 as he/she rolled by. 3. During an interview on 4/22/26 at 5:41 P.M., Licensed Practical Nurse (LPN) E said Resident #1 was originally placed on the 3rd floor locked unit for behaviors. He/She was moved to the 1st floor, where he/she was pleasant. On 4/9/26, a UA was ordered because the resident was not acting normally. Then, he/she was fighting. He/She had a systemic UTI, which was affecting him/her. Staff sent him/her out to the hospital. The resident returned to the facility today at 5:00 P.M. and already attacked LPN E. LPN E attempted to remove the resident's bandage to complete a skin assessment and the resident scratched LPN E. During an interview on 4/23/26 at 2:50 P.M., LPN BB said Resident #1 was being different. He/She was on antibiotics for UTI when he/she went to the hospital. After the resident returned to the facility, he/she was placed on increased monitoring. During an interview on 4/24/26 at 10:16 A.M., the Director of Nurses (DON) said if there was an altercation, there would be monitoring of the resident for 72 hours. She would have to check the policy, but this monitoring is a nursing standard. During an interview on 4/24/26 at 3:38 P.M., the Administrator said she expected residents to be free from abuse and for staff to follow the facility's Abuse and Neglect policy. If a resident displayed a change in behavior or had an increase in behaviors, she would expect staff to continue to monitor the resident and document it in the medical record. Following the physical altercations, the resident was supposed to be on increased monitoring from staff. 298380229875162987523

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Base on interview and record review, the facility failed to review and administer hospital admission orders for one resident (Resident #39), when staff failed to administer an ordered antibiotic to treat the resident's urinary tract infection (UTI). Additionally, staff failed to implement a physician's order for a protective boot for one resident (Resident #16) and failed to follow up on physician's referrals for skilled therapy for two residents (Residents #16 and #90). The sample was 33 and the census was 149. Review of the facility's Transcription of Orders/Following Physician's Orders policy revised on 05/24, showed: The purpose of this policy is to outline procedures in accurately transcribing physician's orders and to ensure that all physicians' orders are followed. To ensure a process is in place to monitor nurses in accurately transcribing and following physician's orders. Upon receiving a physician's order via telephone, fax, written order, verbal order, transcribed order or other, it will be documented in residents' electronic medical records in the orders section. 1.Review of Resident's #39's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/19/26, showed:-Severely impaired cognition;-Partial/moderate assistance from staff for activities of daily living (ADLs);-Diagnoses included anxiety, suicidal ideation (SI) (ideology of self-harm), depression (extreme sadness), post-traumatic stress disorder (PTSD) (flashbacks, nightmares and distress from experiences witnessed/events) and cerebral palsy (permanent neurological damage affects movements and brain development). Review of the resident's progress notes showed staff did not document why or when the resident went to the hospital. Review of the hospital discharge instructions, dated [DATE] at 9:16 P.M., showed:-Concern for a UTI;-An order dated 04/20/26, showed: Cephalexin (antibiotic) 500 milligram (mg) capsule, take one capsule 500 mg by mouth four times a day for seven days, end date 04/27/26. Review of the electronic physician's order sheet (ePOS) showed no order for Cephalexin. Review of the April 2026 medication administration record (MAR) showed no order for Cephalexin. During an interview on 04/22/26 at 6:31 A.M., the Director of Nursing (DON) said she was unaware of the hospital discharge instructions. She said the resident returned after she had left for the day. During an interview on 04/24/26 at 3:41 P.M., the DON said, she and the Assistant Director of Nursing (ADON), were responsible to review discharge instructions. She was unaware the resident had a UTI. She said if left untreated, the risks factors included sepsis, confusion, and change of mental behavior. During an interview on 04/24/26 at 3:41 P.M., the Administrator said the ADON and DON audited hospital discharge instructions the next day. 2. Review of Resident #16's admission MDS, dated [DATE], showed:-Severely impaired cognition;-Partial/moderate to full dependent assistance from staff for a ADLs;-Diagnoses included muscle weakness, lack of coordination, abnormal posture, and stroke. Review of the care plan, in use at the time of survey, showed:-Problem: Has limited physical mobility and uses a manual wheelchair for mobility;-Outcome: Will maintain current level of mobility;-Interventions: Requires maximum assist with locomotion (mobility). Review of the ePOS dated 04/16/26, showed an order dated 08/27/25, for cushion boot to right foot while out of bed, for protection daily. Observation and interview on 04/19/26 at 10:37 A.M., showed the resident did not have his/her protective boot on. The resident said he/she had a decline in ADLs and staff never put on his/her protection boot. Observation on 04/23/26 at 8:43 A.M., showed the resident did not have a boot on his/her right foot. Review of the MAR, showed:-On 04/19/26, staff documented protective boot on per order;-On 04/23/26, staff documented protective boot on per order. During an interview on 04/23/2026 at 8:48 A.M., Certified Nurse's Assistant (CNA) GG said he/she never saw protective boots on the resident. During an interview on 04/23/2026 at 9:09 A.M., Licensed Practical Nurse (LPN) R said the resident did not have a protective boot. Review of the physician's progress note dated 04/7/26, showed: Encourage participation in physical therapy (PT) for mobility and contractures management. During an interview on 04/23/2026 at 9:19 A.M., the Director of Physical and Occupational (Director PT/OT) said therapy (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff did not put the boot on the resident. She was unaware of any new orders for the resident to be referred back to PT services. She said the doctor's note from 04/7/26 was a referral for therapy. She said the resident should have been evaluated. 3. Review of Resident #90's admission MDS, dated [DATE], showed:-Impaired cognition;-Maximal assistance from staff for ADLs;-Received scheduled pain medication regimen;-Diagnoses include reduced mobility, pain in left shoulder and left knee, chronic pain syndrome (pain lasts for months after an injury or after healed) and diabetes. Review of the care plan in use at the time of survey, showed:-Problem: This resident had left shoulder pain;-Outcome: The resident will not have an interruption in normal activities due to pain; -Interventions: Administer pain medications, anticipate the need for pain medication and respond immediately to any complaint of pain;-Problem: Resident had limited physical mobility;-Staff did not document a goal or intervention. Review of the physician's progress dated 04/7/26, showed encourage PT evaluation for mobility and knee rehabilitation for management of shoulder pain. Review of the ePOS showed no current order for PT evaluation. Review of the nurse's progress notes showed no documentation for PT evaluation. 4. During an interview on 04/24/26 at 3:41 P.M., the DON said she expected staff to follow policy and procedures set by the facility. She said the ADON and DON were responsible to audit physician's orders. She would expect staff to notify the doctor of any new changes or orders from referral physicians. 1619729

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents requiring assistance with activities of daily living (ADLs) received necessary services when staff left one resident soiled for an extended period (Resident #155), and failed to provide hygiene assistance for one resident (Resident #6), and supervision during meals for one resident (Resident #110). The sample was 33. The census was 149. Review of the facility's ADL policy, dated 5/18/24, showed:-Purpose: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable;-Cares and services will be provided for the following ADLs;--Bathing, dressing, grooming and oral care;--Transfer and ambulation;--Toileting;--Eating to include meals and snacks. 1. Review of Resident #155's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by the facility staff, dated 3/8/26, showed:-Cognitively intact;-Dependent on staff for toileting hygiene, bathing, upper and lower body dressing, and bed mobility;-Always incontinent of bowel and bladder;-Diagnoses included heart failure, diabetes, and respiratory failure. Review of the resident's care plan, revised 1/8/26, showed:-Problem: The resident has an ADL self-care performance deficit related to rheumatoid arthritics (an auto immune disease that attacks the joints) and generalized weakness;-Interventions: The resident is dependent on staff for toilet use and bed mobility. The resident requires substantial to maximum assist with bathing and dressing;-Problem: The resident is incontinent of bowel and bladder;-Interventions: The resident uses disposable briefs, change as needed. Clean the peri-area (anal and genital area) with each incontinent episode. Check the resident as needed. Provide incontinent care. Review of the resident's face sheet, undated, showed diagnoses included spinal stenosis (narrowing of the spinal canal), morbid obesity, and muscle wasting. Review of the resident's Braden Scale (a measurement if the resident is at risk for developing pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure of friction), dated 4/20/26, showed a score of nine (the resident is at high risk for developing a pressure ulcer). Observation on 4/20/26 at 2:45 P.M., showed the resident lay in bed and Certified Nursing Assistant (CNA) HH and CNA X assisted the resident with turning to his/her right side. The resident's brief and bed pad were saturated with urine and liquid stool. During an interview, CNA X said he/she last changed the resident after breakfast, around 9:30 A.M. During an interview on 4/21/26 at 7:20 A.M., the resident said he/she urinates a lot because he/she is on a water pill. He/She has been having diarrhea lately. The night shift usually changes him/her before they leave at 6:00 A.M., and then the resident doesn't get changed again until around noon. During an interview on 4/24/26 at 10:20 A.M., CNA KK said incontinent residents are to be checked every two hours and as needed or as requested by the resident. It is important to keep the resident clean and dry so no skin issues develop. During an interview with on 4/24/26 at 12:10 P.M., Licensed Practical Nurse (LPN) E said incontinent residents should be checked every two hours and as needed. It is important that residents stay clean and dry so no new skin issues occur. It is also a dignity issue because LPN E wouldn't want to lay in his/her own excrement for long periods. During an interview on 4/24/26 at 3:41 P.M., the Director of Nurses (DON) said she expected staff to check on incontinent residents every two hours. She expected all residents to be clean, dry, and odor free. 2. Review of Resident #6's annual MDS, dated [DATE], showed:-Impaired cognition;-Partial to moderate assistance from staff is needed with personal hygiene, bathing, toileting, and dressing;-Diagnoses included lack of coordination, reduced mobility, muscle weakness, unsteady on feet, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and cognitive communication deficit (inability to communicate). Review of the resident's care plan, in use at the time of survey, showed:-Problem: Resident is at risk for ADL self-care performance deficits related to impaired cognition and schizophrenia;-Outcome: Will maintain current level of function in ADLs through the review (continued on next page)

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	265585	A. Building B. Wing	04/24/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated;-Interventions: The resident is independent with dressing with setup assist, supervision is needed with hygiene, and toilet assistance with setup. Review of the resident's electronic medical record, showed:-A care plan meeting note, dated 3/17/26 at 1:48 P.M., in which staff documented the resident needed a haircut, shave, and wanted his/her nails trimmed. The resident said he/she needed more shirts, pants and socks. Staff to follow up;-No documentation of resident refusals to receive hygiene assistance;-No documentation of bathing assistance provided. Observation on 4/19/26 at 11:01 A.M., showed the resident with messy hair and dressed in a stained white shirt and jeans. The resident's fingernails long and yellow. During an interview on 4/19/26 at 11:01 A.M., the resident said his/her fingernails needed to be cut. Observation on 4/20/26 at 7:55 A.M., showed the resident wore the same stained white t-shirt and jeans from 4/19/26. Observation on 4/21/26 at 7:39 A.M., showed the resident in the same stained white-t-shirt and jeans from 4/19/26. During an interview on 4/21/26 at 8:42 A.M., the resident said he/she wanted his/her clothes changed. Observation on 4/22/26 at 11:58 A.M., showed the resident in the same stained white t-shirt and jeans from 4/19/26. During an interview on 4/23/26 at 8:24 A.M., CNA AA said most of the residents do not have clothes. Now that the elevators are down the laundry personnel have not brought the clothes to the floors. At this time, the resident does not have clothes. During an interview on 4/23/2026 at 8:24 at A.M., CNA L said he/she believed the resident was scheduled for showers on the evening shift. During the interview, CNA L checked the shower book at the nurse's station and noted the resident was scheduled for showers on Wednesday and Saturdays. 3. Review of Resident #110's quarterly MDS, dated [DATE], showed:-Diagnoses included diabetes, muscle weakness, chronic kidney disease, dementia, depression, heart failure, and reduced mobility;-Supervision required during meals;-Severe cognitive impairment. Review of the resident's care plan, in use at the time of the survey, showed:-Problem: The resident has an ADL self-care performance deficit;-Desired outcome: The resident will maintain current level of function in ADLs through the review date;-Interventions: Supervision while eating. Observation on 4/19/26 at 1:08 P.M., showed the resident in bed. His/Her bedside table to the right of the bed out of reach of the resident. A tray of untouched food on the bedside table. Observations of the resident on 4/20/26, showed:-At 7:48 A.M., the resident in bed. He/She attempted to grab his/her drink off the bedside table positioned to the right of the bed. He/She was unable to reach the drink. The resident's privacy curtain pulled and the room door closed;-At 8:44 A.M., the resident in bed. A plate of breakfast on his/her lap. His/Her side table with his/her drinks positioned to the right of the bed, out of reach of the resident. The privacy curtain pulled and the room door closed. During an interview on 4/24/26 at 6:55 A.M., CNA L said the resident sometimes needed encouragement from staff to come to the dining room to eat. He/She preferred to eat in his/her room. CNA L expected staff to supervise the resident during mealtimes. During an interview on 4/24/26 at 4:13 P.M., the Administrator and DON said staff should supervise the resident during meals, if indicated on the resident's care plan and MDS. They expected staff to ensure bedside tables, food, and drinks were in reach of residents. 298757029832672990492

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to thoroughly assess and monitor two residents after resident-to-resident altercations resulted in injuries (Residents #49 and #111). Resident #49 received an x-ray to the right hand on 4/18/26 with results reported on 4/19/26. The facility failed to review the x-ray results until 4/24/26, which showed a fracture to the right hand. The facility failed to follow physician's orders for a hand splint and ice. The facility failed to initiate neuro checks for Resident #111 after being struck on the head during an altercation. Resident #111 had complaints of pain as late as 4/24/26. In addition, the facility failed to provide wound treatment for two residents (Residents #120 and #113). The sample size was 33. The census was 149. Review of the facility's Intensive Monitoring policy, reviewed 4/30/24, showed:-Procedure: Residents who require more intensive monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by the facility staff;-Intensive monitoring: Intensive monitoring is provided as periodic (hourly, every two hours, or every shift) check by a facility staff member;-Residents may require more intensive monitoring based on their crisis, behavioral, psychiatric issues. The level of Intensive Monitoring shall be identified by the specific situation or resident assessment;-Residents who are showing poor impulse control including crisis, behavioral, psychiatric issues, such as, verbal/physical aggression, elopement ideations, suicidal/homicidal ideations, and decompensation mentally or crisis may be placed on intensive monitoring or one-to-one or two-to-one (within eyesight of staff) monitoring at the discretion of the administrative staff or facility supervisor;-Based on the assessment of the resident at the discretion of the administrative staff of Facility Supervisor, either intensive monitoring, one to one or two to one;-Residents who require intensive monitoring of one to one will have an assigned employee within eyesight until resident has stabilized or returned to prior level of function. Educated on the reasoning for the intensive monitoring, including triggers and interventions for that specific resident. The employee will interact with the resident throughout to receive therapeutic interventions;-The facility's Interdisciplinary Team will address the residents' behavioral concerns and ensure interventions are in place to address the residents' needs (psychiatry follow up, counseling, medical needs, etc.);-Once the resident has stabilized and/or returned to prior level of function, the facility's Interdisciplinary Team will meet to discuss determination of discontinuation of Intensive Monitoring;-The facility staff will document the intensive monitoring in the residents Electric Medical Record. Review of the facility's wound treatment management policy, last revised 5/3/24, showed:-Purpose: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatment in accordance with current standards of practice and physician orders;-Policy:--Wound treatments will be provide in accordance with physician orders, including cleansing method, type of dressing and frequency of dressing change;--In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders;--Treatment decisions will be based on cause of the wound, characteristics of the wound, size, volume and characteristics of drainage, presence of pain, presence of infection condition of the tissue in the wound bed, condition of the skin surrounding the wound bed;--Location of wound;--Goals and preferences of the resident or representative;--Treatment will be documented on the treatment administration record (TAR) or in the electronic health record;--The effectiveness of treatment will be monitored through ongoing assessments of the wound. 1. Review of Resident #49's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/1/26, showed:-Diagnoses included coronary artery disease, high blood pressure, non-Alzheimer's dementia, seizure disorder, anxiety;-No cognitive impairment;-No verbal or physical behaviors;-Uses wheelchair;-No scheduled pain medication regimen in the last five days;-Pain frequency: occasionally;-Pain intensity: 2/10;-Antidepressant administered in the last seven days. Review of facility's investigation, dated 4/18/26, showed Resident #49 stated Resident #1 came into their room (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and closed the door behind him/her. Resident #49 stated that he/she was attempting to leave out. Resident #49 said what's up to Resident #1. Resident #1 stated, what can be up. Resident #1 proceeded to grab the wheelchair pedal and hit Resident #49 on his/her right hand. Resident #49 then got up and pushed Resident #1 over his/her bed and a few other items laying around. Resident #49 then left the room and proceeded down the hallway. Once Resident #49 came back up to the floor and passed Resident #1 again, Resident #1 attempted to swing on him/her again and he/she ducked the swing. Review of the resident's care plan, in use during survey, updated 4/19/26, showed:-Problem: On 4/17/26, resident was the recipient of physical aggression by another resident;-Interventions: Resident assessed for pain and injury; Skin assessment performed. Review of the resident's progress notes, showed:-On 4/18/26 at 6:14 P.M., resident has complaint of pain to right hand, swelling noted, physician notified. New order for x-ray to right hand. All appropriate parties notified;-On 4/18/26 at 7:01 P.M., skin check: New skin issue;--Location: right dorsum right hand;--Issue type: other skin issue;--Description: Swelling wound acquired in-house;--Painful: no. Review of the resident's physician order sheet (POS), dated April 2026, showed an order dated, 4/18/26, hand 2-views- right, one time. Review of the resident's x-ray results, showed:-Examination date: 4/18/26;-Reported date: 4/19/26;-Procedure: Hand 2 view- RT (right);-Findings: images of the right hand are submitted. There is an acute fracture of the neck of the fourth metacarpal (sub capital or boxer's fracture, the bone in the hand connecting the ring finger to the wrist) with appropriately 50 degrees of volar angulation (fracture deformity where the distal bone fragment tilts toward the palm side of the hand) and mild displacement. There is associated soft tissue swelling. The remaining hand is intact. There is mild joint degeneration;-Conclusion: Acute fracture of the right 4th metacarpal neck. During an interview on 4/24/26 at 8:34 A.M., Resident #49 said he/she was roommates with Resident #1, but not anymore. The first incident happened when Resident #1 swung on him/her and he/she threw the resident on the ground. Resident #1 was standing at the time in between the bed and dresser. When Resident #1 returned to the room, Resident #49 was sitting on the bed. Resident #1 came in and hit him/her with a wheelchair foot peddle on his/her right hand. Resident #49 pointed out the peddle that was used was on the floor under the bed frame. The foot peddle was already off, so he/she grabbed it. After Resident #1 hit him/her with the foot peddle, Resident #49 said he/she jumped up and punched Resident #1. The punch was nothing bad because his/her hand was hurting. Resident #1 was laughing and said, I'll be back. No staff entered the room. Resident #49 reported it to staff and told them to come get him/her. They did not come when the incident occurred. The resident said his/her right hand continued to hurt. No one did anything and it was still swollen. Resident was asked to hold both hands straight out, with palm of hands facing down. The resident's right hand was noticeably more swollen than the left hand in the knuckle area of the hand. The resident was asked if he/she was able to close the hand into a fist. He/she could not. It hurt too bad and still hurts today. The resident attempted to close hand into a fist; however, the right hand was only cupped. During an interview on 4/24/26 at 8:35 A.M., the Assistant Director of Nursing (ADON) said she was aware of the incident between Resident #1 and Resident #49. She was not aware of the x-ray results. She read the results in the medical record. The ADON said she would expect the results to had been reviewed when it was completed on 4/18/26. She would notify ortho and the physician at that time. During an interview on 4/24/26 at 9:07 A.M., Registered Nurse (RN) EE said he/she was not aware of the resident's hand fracture, and the resident did not have complaints of pain. During an interview on 4/24/26 at 9:08 A.M., Licensed Practical Nurse (LPN) BB said if a resident had an order for an x-ray, it was passed on report and the results were somewhere in the record, under results. If the x-ray technician came, they would let each other know that the resident had an x-ray and keep checking the results. If they did not come, they would pass that on report. Everyone checked for results and once everything was in, they would contact the doctor to receive further instructions if there was an issue. If the results were within normal limits, they would fax the results. During an interview on 4/24/26 at 9:09 A.M., LPN E said the resident was supposed to have a hand x-ray. He/She was asked if he/she was aware of the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	results. LPN E said no. During an interview on 4/24/26 at 9:15 A.M., the ADON said Resident #49 had an orthopedic appointment, so the physician was aware of the results. The ADON would expect on-going monitoring of the resident's hand. It should be documented, but the nurse was monitoring it. During an interview on 4/24/26 at 9:18 A.M., LPN BB said he/she became aware of the fracture today. He/She was aware of the altercation that occurred. He/She asked Resident #49 if he/she was doing alright and the resident said, I'm fine. He/She monitored the resident's hand but did not document it. When the incident happened, he/she was off and did not work for a few days. During an interview on 4/24/26 at 9:30 A.M., LPN E said Resident #49 did not have complaints of pain. He/She completed the regular/daily rounds and the resident did not report anything. LPN E monitored the hand at the time of the x-ray. It was swollen, but the swelling went down. He/She looked at the hand and it was not as swollen. It was not daily. Resident #49 is completely self and would let them know. He/She did his/her normal joking, but did not say they were in pain. He/She did not know Resident #49 was in pain until now. He/She asked the resident if he/she was in pain, and the resident said yes. During an interview on 4/24/26 at 9:49 A.M., the ADON said there was an appointment slip that showed the resident had an orthopedic appointment on 4/30/26. The ADON was unaware of who completed the form, made the appointment, or contacted the physician. Review of the resident's transportation referral, showed:-Appointment date: 4/30/26 at 10:20 A.M.;-Type of doctor: Orthopedic;-Reason for appointment or special instructions: Fracture to finger on right hand. During an interview on 4/24/26 at 10:40 A.M., Physician DD remembered the incident. He/She was notified and ordered an x-ray to Resident #49's right hand. He/She was aware of the results of the x-ray, but did not remember who called him/her. He/She ordered hand splint, ice, and an ortho consult. He/She would expect the orders to be followed for the splint, ice, and ortho appointment. He/She would expect staff to continue to monitor and assess for pain until the resident's ortho appointment. The fracture was not considered emergent and was seen by ortho. Depending on the age of the patient, it may just be splint and monitoring for pain. He/She would expect the resident to wear a splint to reduce mobility and further injury. 2. Review of Resident #111's modified quarterly MDS, dated [DATE], showed:-No cognitive impairment;-Diagnoses included non-traumatic spinal cord dysfunction, anemia, high blood pressure, neurogenic bladder, hyperlipidemia, malnutrition, depression,-No verbal or physical behaviors;-Uses wheelchair;-No scheduled pain medication regiment in the last five days. Review of the resident's care plan, in use during survey, showed:-Problem: On 4/17/26, resident was the recipient of physical aggression by another resident;-Desired outcome: Ensure protective oversight is provided;-Interventions: Resident assessed for injury and pain. Skin assessment performed. Review of the facility's investigation, an undated interview, showed per Resident #111, when he/she got off the elevator, Resident #1 said he/she killed his/her kid or baby and swung on him/her. Per Resident #111, he/she did not know what he/she was talking about. Review of the resident's progress notes, showed:-On 4/18/26 at 12:01 A.M., Skin check: skin warm and dry, skin color within normal limits, and turgor is normal. No skin issues identified;-On 4/18/26 at 7:04 P.M., Skin check: skin warm and dry, skin color within normal limits, and turgor is normal. No skin issues identified. Review of the resident's POS, dated April 2026, showed: -An order, dated 12/11/24, Acetaminophen Oral tablet 325 mg, give two tablets by mouth every four hours as needed for pain;-An order, dated 4/18/26, skull complete, minimum four view. Sent for imaging on 4/18/26. Review of the resident's MAR, dated April 2026, showed:-An order, dated 12/11/24, Acetaminophen Oral tablet 325 mg, give two tablets by mouth every four hours as needed for pain, showed no documentation of administration between 4/1/26 through 4/24/26. Review of the resident's x-ray results, showed:-Examination date: 4/18/26;-Reported date: 4/18/26;-Procedure: Skull complete, min 4V (minimum four views);-Findings: The bony calvarium appears intact, with no fracture identified. There are no suspicious lytic (destruction of cells) or sclerotic lesions (hardened bone). There is grossly normal mineralization. No focal soft tissue abnormality is identified;-Conclusion: Unmarkable skull. Review of the resident's medical record, showed no documentation of neuro checks or on-going (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	monitoring of the resident's injury and pain after 4/18/26. During an interview on 4/24/26 at 9:23 A.M., Resident #111 said the fight was out in the hallway. Resident #1 punched him/her in the face. He/She was struck on the left side of the face. It still hurts too. Resident #1 used a closed fist. Resident #111 did not hit Resident #1. Staff came and got the resident after Resident #1 struck him/her. During an interview on 4/24/26 at 9:30 A.M., LPN E said Resident #111 did not have complaints of pain. He/She completed the regular/daily rounds and the resident did not report anything. During an interview on 4/24/26 at 10:40 A.M., Physician DD said if a resident was struck in the head, he would have expected staff to initiate neuro checks. They were expected to routinely assess and monitor the resident's face for any changes. During an interview on 4/24/26 at 10:16 A.M., the DON said she would expect there to be 72 hour monitoring following resident to resident altercation but would have to verify the policy. It was a standard nursing judgement. If staff made the ortho appointment and was aware of the Resident #49's fracture, she would expect it to be documented. The monitoring should include if there was limited mobility, if resident needed help, or pain medications. Would expect the physician to be notified. She would expect documentation if there were suggestions or orders from the physician, suggestions or what to monitor until the resident's ortho appointment. She would expect the same for Resident #111. Staff was expected to monitor for pain and swelling. 3. Review of Resident #120's quarterly MDS, dated [DATE], showed:-Mild cognitive impairment;-Independent with bed mobility and ambulation;-Requires set up from staff for upper and lower body dressing and bathing;-Diagnoses included heart disease, heart failure, depression, anxiety, kidney disease and Parkinson's disease. Review of the resident's care plan, in use at the time of survey, showed;-Focus: The resident is as risk for limited physical mobility related to Parkinson's disease;-Interventions: The resident does not require any assistive device and ambulates independently;-Focus: The resident is at risk for impairment to skin;-Interventions: Follow facility protocol for treatment of injury; Monitor and document location, size, and treatment of skin injury; Report abnormalities, failure to heal or signs and symptoms of infection. Review of the resident's progress notes, showed on 4/17/26 at 12:13 P.M., the resident signed him/herself out and walked out of the building. Staff members found the resident on the ground outside of the facility. The resident was sent to the hospital. Review of the resident's TAR, showed:-An order, with a start date 4/18/26, cleanse right hand sutures with normal saline (salt water), apply triple antibiotic ointment (TAO) for two days then cover with Vaseline daily until healed.-The treatment was documented as completed 4/8 through 4/23/24;-The treatment did not include applying dressing. During observation on 4/19/26 at 9:50 A.M., 4/20/26 at 2:30 P.M., and 4/21/26 at 8:05 A.M. the resident had a white surgical dressing to his/her right hand. During an interview 4/19/26 at 9:50 A.M., the resident said he/she has had the same dressing on since the hospital. No staff member has removed it or applied any type of ointment. During an interview on 4/23/26 at approximately 2:00 P.M., the resident no longer had dressing on his/her right hand and said he/she removed it him/herself because the same dressing was on for several days. The resident said he/she had been washing his/her right hand with soap and water. The hospital informed the resident that the sutures were self-dissolving. During an interview on 4/24/26 at 12:10 P.M., LPN E said he/she had been changing the dressing daily to the resident's right hand and did not have a marker to write the date on the dressing. All nurses were responsible for completing treatments and dressing changes. 4. Review of Resident #113's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Dependent on staff for putting on and taking off footwear and lower body dressing;-Requires substantial to maximum assist with bathing and toileting hygiene;-Diagnosis included high blood pressure. Review of the resident's care plan, in use at the time of survey, showed:-Problem: The resident has an activities of daily living (ADL's, bathing, dressing and toileting) self care performance deficit related to weakness and immobility related to pain;-Focus: The resident requires physical assistance by staff with his ADLs: bed mobility, toileting, transfers, ambulation, dressing, bathing and personal hygiene.-The care plan did not address the resident's toe wound. Review of the resident's progress notes, showed:-On 4/1/26 at 11:32 A.M., the resident's (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	right second toenail on his/her right foot came off during resident care; The wound was cleansed with wound cleaner; Wound gel was applied; ABD pad (a specialized dressing) was applied and wrapped with Coban (a specialized stretchy wrap);-On 4/20/26 at 3:24 P.M., the resident has a facility acquired open wound to his/her second toe nailbed on his/her right foot.-No further documentation or description of the resident's right second nailbed toe wound. Review of the resident's TAR, dated April 2026, showed:-An order with a start date 4/2/26, clean wound to right foot with wound cleaner, apply wound gel, cover with ABD and wrap with Coban daily;-The treatment was documented as completed on 4/2 through 4/24/26. Observation on 4/20/26 at 7:55 A.M. and 4/22/26 at approximately 3:00 P.M., showed the resident did not have dressing to his/her right foot second toe. The second toe nail bed was scabbed over with no drainage. The resident said a staff member was removing his/her bed sheet and his/her toenail got caught and pulled the toenail off. The resident said that the staff was only dressing the toe for the first couple of days after the incident happened and then the nurse decided to leave the toe wound open to air. During an interview on 4/24/26 at 12:10 P.M., LPN BB said the resident had current treatment orders for his/her right foot, second toe. The last few days LPN BB had been leaving the dressing open to air. LPN BB didn't think she was signing off the dressing change was completed but wasn't sure. All nurses were responsible for completing and documenting the wound treatments. During an interview on 4/22/26 at 9:32 A.M., the DON was not made aware of the incident with the resident's toe on his/her right foot. Staff was expected to inform her of any new skin issues because she was also the Wound Nurse. She would expect staff to reach out to her regarding adding or discontinuing treatments. 5. During an interview on 4/24/26 at 3:41P.M., the DON said she would expect staff to follow the physician orders and document the wound treatments only when completed. If a wound treatment is changed for any reason, there should be new orders placed in the electronic medical record (EMR). Intake: 2987516

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	265585	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Health Care 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to provide care to prevent pressure ulcers for one resident (Resident #90). Staff did not provide a treatment to the resident's wound as the physician ordered and left the wound exposed to air. Staff also did not update the resident's care plan after they discovered the resident had a pressure wound. The sample size was 33. The census was 149. Review of the facility's Pressure Ulcer Management policy dated 05/24, showed:-Purpose: The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries;-Definitions: Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device;-Policy: Assessment of Pressure Injury Risk:---Licensed Nurse (Registered Nurse (RN) and Licensed Practical Nurse (LPN) will conduct a pressure injury risk assessment using the Braden Scale for predicting Pressure Score Risk, on all residents upon admission/readmission, weekly, then quarterly, and whenever the resident's condition changes significantly;--Intervention for Prevention and to Promote Healing:---After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that included measurable goals for prevention and management of pressure injuries with appropriate interventions;---Evidence-based intervention for prevention will be implemented for all resident who are assessed at risk or who have pressure injury events present. Basic or routine care interventions could include, but not limited to:---Redistribute pressure (such as repositioning, protecting, and/or offloading heels, etc.)---Provide appropriate, pressure-redistributing, support surfaces,--The goals and preference of the resident and/or authorized representative will be included in the plan of care;---Interventions will be documented in the care plan and communicated to all relevant staff;---Compliance with interventions will be documented in the weekly summary chart;--Monitoring: The Director of Nursing (DON) and Assistant Director of Nursing (ADON) or designee, will review all relevant documentation regarding skin assessments, pressure injury risk, progression towards healing, and compliance at least weekly, and document a summary of finding in the medical record; Review of Resident #90's Annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/01/26, showed:-Impaired cognition;-Maximal assistance from staff for activities of daily living (ADLs);-Diagnoses included: Reduced mobility, pain in left shoulder and left knee, chronic pain syndrome (pain lasts for months after an injury or after healed) and diabetes;-At risk for pressure injury;-Current number of unhealed pressure injuries : zero; Review of the care plan, in use at the time of survey, showed the care plan did not reflect the resident had a Stage 2 pressure ulcer (partial-thickness skin injury appearing as a shallow, open ulcer with a pink/red wound bed). Review of the current electronic physician's order sheet (ePOS) showed:-An order dated 04/06/26: Treatment to left buttocks, cleanse area with soap and water, pat dry, apply triple antibiotic ointment (TAO) and cover with border gauze dressing two times daily (BID) at 9:00 A.M., and 5:00 P.M. Review of the Treatment Administration Record (TAR) showed the resident received the wound treatment 28 out of 29 opportunities with the last change on 4/21/26 around 9:00 A.M. Review of the Wound report on 04/19/2026 at 12:26 P.M., showed the resident had a stage 2 pressure ulcer Location: Left buttocks Etiology: Pressure Ulcer/Injury, Stage/Severity: Stage 2, Acquired in House: Yes, Date Wound Acquired: 04/07/2026, Wound Status: New. Observation on 04/22/26 at 4:20 P.M., showed the resident's left buttocks had no dressing, and the wound was open to air. The surrounding area was discolored. During an interview on 04/22/26 at 11:42 A.M., Licensed Practical Nurse (LPN) R said the resident has a cushion and two small areas open on his/her back side. LPN R said they are to put a barrier cream on at night and keep the wound open to air. This wound was just discovered a couple of weeks ago. During an interview on 04/22/26 at 4:20 P.M., the Director of Nursing (DON) / Treatment Nurse said the wound site should have TAO and a bandage (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	over it. The DON said the resident did not have a bandage on, and the resident was at risk of an infection due to an improperly covered wound. During an interview on 04/23/26 at 9:26 A.M., Care Plan designee said care plans are updated every 90 days. The meetings are held, and revisions are done on Tuesdays and Thursdays. The care plan will address the concerns of the resident. 2983573

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview and record review, the facility failed to provide behavioral health care services to address one resident's (Resident #84) known history of self-harming behavior. The facility failed to develop and implement care plan interventions related to the self-injurious behaviors, failed to develop a safety plan for the resident, and to timely refer the resident to psychiatric services, resulting in self-mutilating behaviors of biting off his/her fingers when he/she became frustrated or angry. The facility also failed to address one resident's aggressive behavior and pulling the facility fire alarm multiple times. (Resident #39) The sample was 33. The census was 149. The Administrator was notified on 4/23/26 at 10:06 A.M, of an immediate jeopardy (IJ) which began on 4/21/26. The IJ was removed on 4/23/26 as confirmed by surveyor on-site verification. Review of the facility's Behavioral Emergency Policy, last revised 9/23/25, showed:-Purpose: To provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care for the resident in a behavioral crisis, to ensure that the resident is not coerced, punished, or disciplined for staff convenience;-Principles: As part of this commitment, leadership explicitly adopts the following principles and values regarding physical holds and the administration of medication: -Use of physical holds and administration of medication is seen as safety intervention of last resort, rather than a treatment interventions per se, and its usage should be a crisis event; -An organization's philosophy of giving the highest priority to all non-violence is to be articulated in all policies, procedures, and practices; -Practices that are sensitive to those with a history of trauma are to be in place; -Key models are to be identified that support a culture of individual empowerment and recovery that is supportive, compassionate, and non-punitive; -An environment of care is to be created that is welcoming, attractive, and as adaptable as possible;-Interventions: -Non-Physical and Proactive: It is the policy of the facility to provide a safe environment and provide humane care to all residents. Non-Physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention. The facility's approved early interventions crisis prevention techniques will be used to de-escalate conflict when possible. Care will be guided by residents' plan of care and based on the strategies taught by Crisis Prevention Institute non-violent crisis intervention, or the current company guidance, and will help to respond to difficult behaviors in the safest and most effective way possible. Proactive management for our residents is the best plan. All staff should recognize when the resident has become or can become a danger to themselves or someone else. De-escalation techniques shul be utilized as first resort;-Steps for crisis intervention: -Should the resident exhibit extreme behaviors such as suicidal, homicidal, self-mutilation, elopement, or resident to resident altercations which did not respond to the non-violent crisis intervention, the following steps will occur: -The licensed nursing staff and or nursing administration will assess the resident who is displaying signs of crisis, ensuring that safety of the resident and other is the priority. Monitoring of the resident will be initiated, if appropriate; -The facility's Administrative Team will assess to see if the resident's need can continue to be met safely or when the resident continues to be appropriate for placement at the facility; -The facility will notify the physician or psychiatrist of the behaviors emergency. Should the resident require additional hospitalization, coordination of care will occur with the physician and or psychiatrist with receiving hospital to ensure transfer of patient specifics. The guardian, family, or responsible part will be notified of the situation, including current status, hospitalization or other specifics, if applicable; -If the resident is unable to be redirected or is personally requesting a as needed (PRN) medication for mood stabilization, the resident will be given PRN medication per physician orders; If the resident receives an oral, intramuscular mood stabilizing medication, the licensed nurse will document the administration and effectiveness; -The licensed nurse will document the behavioral emergency in the medical record; -The licensed nurse is responsible for notify the administration, physician, and or psychiatrist, an responsible party; -The (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	licensed nurse will document the behavioral emergency in the medical record; -The interdisciplinary team will ensure the care plan is updated if appropriate; -The administrative team will review the in incident to determine root cause and review the situation for contributing factors, Reviewing staff responses and documentation to ensure that the situation is reflected clearly; -Each of the residents who have an increased potential for aggressive behavior toward self or other or show a a history of harm to self or other will have an assessment completed upon admission or prior to the use of approved hold techniques; -The Psychosocial post incident impact questionnaire will be completed during the admission process, and as needed; -Persons providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address individual's behaviors;-Post-Incident:A post incident review with staff members involved shall take place following the procedure tin order to determine: -Any improvements that could be made to reduce the likelihood of reapplication; -Any improvements in the procedure that could have made the event less traumatic; -Assess any trauma reaction on the part of the staff; -Identify what led to the incident and what could be done differently; Root cause determination; -Ascertain that the individual's physical well-being, psychological comfort and right to privacy were addressed; -If identified, offer supportive services for the residents; -The team shall review modifications to the treatment plan made during the crisis and develop a plan;-At regular intervals the facility will review incidents to obtain root cause analysis which will facilitate improvements of care management and further prevention of incidents. Review of the facility's Intensive Monitoring policy, last revised, 4/30/24, showed:-Purpose: To ensure a system is in place for residents who require increased monitoring for crisis, behavioral, and psychiatric issues;-Procedure: Resident who require more intensive monitoring due to crisis, behavioral/psychiatric symptoms will be monitored by the facility staff;-Definitions: -Intensive monitoring is defined as periodic (hourly, every Two hours, or ever shift) check by a facility staff member; -One to one monitoring a designated employee assigned by a facility supervisor. Residents who require intensive monitoring of one to one will have a dedicated staff member within eyesight;-Intensive monitoring: -Residents may require more intensive monitoring based on their crisis, behavioral, psychiatric issues; The level of intensive monitoring shall be identified b the specific situation or resident assessment; -Residents who are showing poor impulse control including crisis, behavioral, psychiatric issue, such as, verbal/ physical aggression, elopement ideations, suicidal/homicidal ideations, and decompensation mentally or crisis may be placed on intensive monitoring o on-to one or two to one (within eyesight of staff) monitoring at the discretion of the administrative staff or facility supervisor; -Based on the assessment of the resident at the discretion of the administrative staff of facility supervisor, either intensive monitoring, one to one or two to one; -Residents who require intensive monitoring of one to one will have an assigned employee within eyesight until the resident has stabilized or returned to prior level of function. Educated on the reasoning for the intensive monitoring, including trigger and interventions for that specific resident; The employee will interact with the resident throughout to receive therapeutic interventions; -The facility's interdisciplinary team will address the residents' behavioral concerns and ensure interventions are in place to address the residents' needs (psychiatry follow up, counseling, medical needs, etc) -Once the resident has stabilized and/or returned to prior level of function, the facility's interdisciplinary team will meet to discuss determination of discontinuations of intensive monitoring; -The facility staff will document the intensive monitoring in the resident's electronic medical record (EMR). 1.Review of Resident #84's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 01/25/26, showed:-Cognitively intact;-Behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds): Behavior of this type occurred one to three days;-Impact on the resident: Does the behavioral symptoms put the resident at significant risk for physical injury: Yes; Does any of the behavioral symptoms significantly interfere (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	with the resident's care: Yes.-Diagnosis includes quadriplegia (partial or complete loss of sensation and movement in all four limbs), neurogenic bladder (inability to urinate on own), depression, and anxiety. Review of the resident's Preadmission Screening and Resident Review (PASSR) , updated 1/30/26, showed:-Prior PASSAR evaluation completed on 04/08/2020. The resident was hospitalized at that time. Resident admitted after he/she bit his/her right index finger to the point that the bone fractured. He/She had been discharged from the hospital on 3/23/2020, then returned to the hospital due to persistent hand pain. Diagnosed with bite wound infection and recurrent urinary tract infection (UTI). Required intravenous (IV) antibiotics for treatment. He/She again developed a wound on his/her index finger, due to biting himself/herself. Requires wound care for this issue. Totally dependent on others for all aspects of personal hygiene and activities of life (AOL). Per nursing facility staff report, the resident has been difficult to deal with due to verbally abusive behaviors. Resident is quadriplegic and is unable to behave in a physically aggressive manner. Frequently hostile to staff, is described as rude and displays a sense of entitlement. Can be very demanding of staff. Requires wound care to his/her index finger and right middle finger. Staff reported he/she will be provided with mental health follow-up as soon as he/she can be worked into the schedule. The resident wants to go to each smoke break. Becomes angry and agitated if this does not occur. Staff reported he/she wants to go back to living with his/her father and does not plan to remain at the nursing facility on a long-term basis;-Psychiatric assessment: Per nursing facility staff report, they are not aware of the resident making any threats to harm himself/herself. Does inflict self-harm by biting his/her middle or index finger on a routine basis. Resident's needs could be met at the nursing home. Review of the resident's care plan showed no listed interventions for self-injury behaviors in January or February 2026. Review of the resident's physician order sheets (POS), dated 04/19/26, showed:-An order dated 01/12/26, may have psychiatric services as needed;-No order for behavioral monitoring. Review of the resident progress notes showed:-On 01/12/26 at 6:46 P.M, the resident was admitted to the facility, skin intact, no complaint of pain or discomfort at this time;-On 01/15/26 at 11:11A.M., blood was noted all over the resident's bed and his/her mouth. The right-hand middle finger was bleeding and missing multiple layers of skin. Pressure applied to the finger. The Certified Nursing Assistant (CNA) was assisting the resident with getting cleaned up, and the CNA witnessed the resident biting his/her finger. The resident did not verbalize why he/she was biting his/her finger. The resident's finger was dressed, and the physician was notified and gave antibiotic orders; At 11:40 A.M., the physician called back and gave order to send the resident to the hospital for self-inflicted wound;-On 01/15/26 at 8:06 P.M., the resident returned from the hospital with new orders for antibiotics. The resident was placed in chair near the nurses' station;-On 01/17/26 at 5:00 A.M, Wound Care Note: The resident is new to wound care services, injury to right middle finger due to resident biting finger due to being frustrated;-On 01/31/26 at 6:21 A.M., the resident remains verbally abusive to staff and cursing at staff. Encouraged resident to stop, but the resident acted as though he/she did not hear the nurse; Redirection unsuccessful;-On 02/16/26 at 1:13 P.M., the resident wound to right hand has opened up due to biting it. The resident was sent to the hospital.-On 02/16/26 at 8:15 P.M., (late entry) Wound Care Note: The resident's right hand middle finger has now developed a large fissure and open laceration to the bone, the finger feels unstable and barely attached; The resident was sent to the hospital;-On 02/24/26 at 6:55 P.M., the resident returned from the hospital. Resident's second finger on right hand unwrapped, finger intact, bruising, scabbing and open areas noted; -On 02/25/26 at 8:10 P.M., Wound Care Note: the resident was seen for laceration for right finger; The wound has improved no visible fissure, scabs noted, color looks good;-On 03/02/26 at 9:20 A.M., the resident was sent to the hospital for biting his/her finger causing it to bleed uncontrollably; The resident said he/she bit his/her finger so that he/she could smoke a cigarette; The resident was sent to the hospital;-On 3/02/26 at 4:26 P.M., the resident returned from the hospital, the resident denied pain and is sitting near the nurse's station;-On 03/04/26 at 10:11 A.M., the resident was sent to the hospital due to the resident biting his/her right-hand finger and bone is exposed. The resident said (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	he/she will continue to bite his/her finger until it falls off. The resident is on 15-minute checks until the ambulance arrives;-On 03/05/26 at 7:18 A.M., the resident was observed biting his/her fingers causing a laceration. The resident said he/she was hungry and did not eat at the hospital. Treatment was completed. Tylenol was administered. Staff will continue to monitor for protective oversight; Review of the resident's care plan, last updated 03/06/26, showed-Focus: The resident is at risk for the following symptoms related to the diagnosis of anxiety, cursing, hollering, leg shaking, moving around in or frequently getting up and down from the chair, nail biting, nervousness, pacing on the unit, restlessness, shaky voice, sweating and toe tapping; -Desired outcome: The resident will have decreased sign and symptoms related to anxiety through next review date;-Interventions: Be aware of your body stance and facial expressions when you approach me; Closely watch the resident for signs of anxiety and act before I lose control; Do not argue or tell me that they are wrong when I am upset; Do not get into a power struggle with the resident; Don't get to close and remember personal space; Offer activities to keep me from getting bored and provide an opportunity to release energy in a healthy way; Offer non-invasive coping mechanisms first to try to reduce anxiety level; Assist with finding the cause of the anxiety;-Focus: At the time of Preadmission Screening and Resident Review (PASRR), a federally mandated requiring that all individuals applying to or living in nursing facilities are screened for serious mental illness, the resident is deemed safe for admission to the skilled facility;-Desired outcome: The resident will remain safe in the facility;-Interventions: Daily living skill training; Develop personal support network; Implement activities of daily living programs; Medically related social services; Pharmacy services; Physician services; Provisions of a structured environment; The resident will be in the least restrictive environment while maintaining protective oversight; Structured socialization;-Focus: The resident is at risk for self-directed violence;-Interventions: Assess suicidal/self-harm thoughts, intent, plan, and means; Collaborate with resident to develop a written safety plan; Encourage the resident to adhere to prescribed medication; Encourage the resident to identify trigger and early warning signs of self-harm urges; Encourage verbal expression of feelings through open ended questions; Establish a therapeutic rapport, use active listening and non-judgmental communication; Maintain a safe environment by removing sharp objects, belts, cords, and toxic substances; Promote physical activities as tolerated; Refer to therapy and psychiatric services as appropriate; Reinforce and praise adaptive coping behaviors; Teach and praise the adaptive coping behaviors; teach and practice alternative coping skills (deep breathing, call a friend, mindfulness and journaling). Review of the resident's, electronic medical record (EMR), dated 4/22/26, showed no safety plan in place or specific interventions identified related to the resident's behaviors of biting him/herself. Review of the resident progress notes showed:-On 03/08/26 at 7:32 P0.M., the resident cursed at a CNA. The resident was upset that the CNA propelled another resident into the dining room before him/her. The resident was informed that name calling was not appropriate. The resident continued to curse;-On 03/11/26 at 8:23 P.M., Wound Care Note: The resident was seen today for laceration to right hand middle finger. Part of the affected finger removed with the dressing change. The resident was sent to the hospital.-On 03/17/26 at 6:39 P.M., the resident returned from the hospital and cursed at staff and wanted to go home. Resident's family member called; Will monitor; Review of the residents' Psychiatry Nurse Practitioner (NP) QQ notes, dated 03/17/26, showed:This is an initial encounter. Patient is noted to be anxious, irritable, withdrawn, avoiding eye contact, and not forthcoming in responding to most assessment questions. He/She is alert person, place and time, currently sitting in his wheelchair. The resident has a history of spinal cord injury with paralysis since 2007. Chart reviews note a history of depression and anxiety, however, he/she refused to discuss his/her psychiatric history during the encounter. Chart review indicates a history of verbal aggression as well as self-harm, including biting his/her finger in the past to the point of fracturing a bone. He/She reportedly becomes irritable and angry with staff related to his significant physical limitations. He/She cannot engage physically. The resident remained focused on wanting to get out of here and get downstairs. He/She appears well cared for, and there were no reports or (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	observations of psychotic symptoms. Chart has been reviewed.Assessment overview: All relevant and available laboratory results have been reviewed, and the patient's medication list has been reconciled. Staff are to contact me with any significant behavioral or emotional concerns, as well as with any questions regarding psychotropic (medications that stabilize mood). Will follow up with the patient on a routine basis;Plan of treatment overview: Staff to monitor any self-harm behaviors and report any concerns promptly. Review of the resident progress notes showed:-On 03/18/26 at 9:19 AM., Wound Care Note: The resident was not seen due to surgical dressing is not to be removed until follow up visit with outside physician;-On 04/15/26 at 8:28 P.M., the resident was seen for right hand finger laceration. The finger has been fully amputated and is fully healed;-On 04/16/26 at 7:39 P.M., the resident bit his/her hand causing excessive bleeding; The resident was sent to the hospital;-On 04/21/26 at 5:10 P.M., the resident arrived back to the facility: the resident is able to make needs known; The resident denies any pain or discomfort: Orders verified by the physician; Plan of care ongoing;-On 04/22/26 at 1:31 P.M., new skin issue right hand fifth digit (pinky finger). The resident was sent to the hospital;-On 04/22/26 at 4:59 P.M., the resident returned to the facility. The resident can make needs known. The physician was notified, and all orders were verified; The resident is agitated and has chronic behaviors to hurt self or others; The resident is chronically disruptive and refuses care.-No documentation of behavioral interventions in place;-No documentation that psychiatry was notified of the resident's ongoing self-harming behaviors;-No documentation that the resident's primary care physician was notified of the resident's ongoing self-harming behaviors. Review of the resident's record showed no further psychiatry notes from the resident's Psychiatry Nurse Practitioner after 3/17/26. Review of the hospital psychiatrist's note dated, 04/21/26 at 6:43 A.M. showed:-Psychiatric diagnoses: Delirium (sudden onset of confusion) resolving and anti-social personality disorder (ASPD, a mental health condition defined by a long-term pattern of manipulation, exploiting, or violating the rights of others).-Additional associated complications: Agitation, violence, self-injurious behavior, impulse control problems, and poor insight and judgement.- Plan: Continuous 1:1 observation indicated: Yes. The resident is at risk of harm to self if not placed on 1:1 observation. During an interview on 04/19/26 at 8:06 P.M., Hospital Registered Nurse (RN) LL said during the 04/16/26 hospitalization, the resident was in wrist restraints, had a sitter and a camera monitoring system was in the hospital room. The resident was hallucinating and trying to bite his/her right hand dressing off. The resident was admitted to the hospital because he/she had completely bit off his/her right ring finger and it could not be reattached. During an interview on 04/22/26 at 1:05 P.M., CNA H said the resident was admitted on evening shift on 4/21/26. The resident was cursing at the ambulance drivers and having a fit on arrival to his/her room. CNA H went to the kitchen and made the resident a peanut butter and jelly sandwich. The resident was happy at that time. CNA H would check on the resident every 15 minutes and keep the resident's door open until he/she left at 11:00 P.M. The resident remained in his/her room alone during the evening shift. The resident started biting his/her right hand and removing the surgical wrap with his/her teeth. CNA H attempted to stop the resident from biting his/her hand. CNA H said he/she told LPN I about the residents' behaviors. The resident should have been on 1:1 a long time ago. The resident has always had behaviors of self-mutilation and yelling at staff. During an interview on 04/22/26 at approximately 4:00 P.M., Licensed Practical Nurse (LPN) I said he/she worked on 04/21/26, evening shift and night shift. The resident returned from the hospital prior to her getting to the facility. He/She was already at the facility. LPN I saw the resident around 3:00 or 4:00 P.M. at the start of the shift. The resident seemed okay in his/her room. The resident voiced no complaints or concerns at that time. The resident had some verbal outbursts, but that was normal. LPN I did not receive report and did not know who received report from the hospital. The resident was always yelling out. He/She had an ace bandage on his/her hand, but LPN I could not remember which hand, but though it was the right. The resident was not on any enhanced monitoring or 1:1. LPN I was not told the resident was to be on 1:1. No one was assigned to do those. No aides reported any behavior, and night shift got the resident up. LPN I was not aware the resident was (continued on next page)

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	265585	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Health Care 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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	starting to bite bandages off of his/her hand. No one reported any behavior or anything. LPN I left after his/her shift at 8:00 AM. on 4/22/26. The resident was sitting in his/her chair, waiting for the dining room to open. The resident was not doing anything out of the ordinary, just talking to people as they go by. LPN I did not look at the resident's right hand bandage at the end of his/her shift. LPN I was aware the resident had self -harm behaviors. If LPN I saw the resident chewing on his/her fingers, he/she would have sent him/her to the hospital. During an interview on 04/22/26 at 12:07 P.M. and 12:17 P.M., the Restorative Aide (RA) V said the resident was out on the patio on 4/22/26 at approximately 9:30 A.M. RA V had to go downstairs and get a smoking apron and an ashtray in order for the resident to smoke. By the time RA V got back with the smoking apron and ashtray, the resident had bit his/her finger off. Activities Aide PP was with the resident, supervising the smoking break. RA V was not aware of any interventions for the resident's self -harm behaviors. RA V was aware the resident had bit his/her fingers off before. RA V was not informed of any 1:1 monitoring for the resident. Everyone in the building knew about the resident's behaviors. The resident did not participate in activities. During an interview 04/22/26 at 12:17 P.M., CNA A said the resident was out on the patio at about 9:30 A.M. on 4/22/26, and he/she started to yell because he/she wanted to smoke immediately. Certified Medicine Technician (CMT) F brought the resident in from the patio because the resident was being disruptive and upsetting the other residents located on the patio. CNA A was not aware of any 1:1 intervention for the resident. During an interview on 04/22/26 at 12:45 A.M. Activities Aide (AA) PP said he/she did not witness the resident bite his/her finger off. AA PP said he/she was out with the residents on the patio for a smoke break at approximately 9:30 A.M. The resident was cursing because he/she wasn't getting his/her cigarette lit fast enough. CMT F removed the resident from the patio because he/she was disruptive and placed him/her in the hall near the patio door. AA PP spoke with CMT F briefly about what they were going to eat for lunch. When CMT F went back inside the resident had bit his/her finger off. AA PP was aware the resident bit off his/her fingers off in the past. The resident had behaviors all the time, like calling staff racial slurs and that he/she was going to rape their children, especially if the resident did not get his/her way. AA PP was not aware of any special interventions for the resident. The residents did not participate in any activities. AA PP would see the resident sitting in the hall sometimes. During an interview on 04/22/26 at 12:58 P.M., CMT F said he/she heard the resident yelling and cursing on the patio on 4/22/26 while he/she was passing medication. CMT F brought the resident out from the patio and there was no blood on the resident at that time. CMT F placed the resident in the hall near the patio door. CMT F went back out on the patio to speak with Activities Aide PP, and when he/she walked back in to assist the resident back to his/her room, the resident had bit his/her pinky finger off and it was laying on the floor. CMT F said it was less than two minutes he/she left the resident unattended. CMT F was not aware of any 1:1 intervention for the resident. During interviews on 04/22/26 at 5:41 P.M., and on 04/24/26 at 12:10 P.M., LPN E said he/she knew the resident was taken to the patio to smoke and then he/she was notified by CMT F that the resident had bit his/her pinky finger off and it was laying on the floor. That was the first time LPN E observed the resident harming him/herself. The only intervention that LPN E knew about the resident's behaviors was to send the resident to the hospital. LPN E said staff should be documenting every shift that the resident is having ongoing behaviors. Staff should also notify the psychiatrist and primary care physician of the resident's ongoing behaviors. Staff should also notify the DON and the Administrator of resident behaviors. The Psychiatric NP comes in once a week or more frequently if the staff call him/her. During an interview on 04/19/26 at 10:30 A.M., CNA KK and CNA MM said the resident always chewed on his/her dressing and fingers on his/her right hand. The resident could move his/her arms and neck to where he/she could reach his/her right hand. The resident constantly yelled and cussed at staff. The resident would also hit him/herself in the head. The resident would mainly be upset about smoke breaks and wanted to go out when it wasn't the designated smoke time. The resident has never been on 1:1 or 15-minute checks. The resident would request to sit in the hall near (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the nurses' station. CNA KK and CNA MM said the resident was difficult to care for and they didn't really know how to deal with the resident. Everyone in the building knew about his/her behavior. CNA KK and CNA MM were not aware of any special interventions that were in place for the resident. During an interview on 04/20/26 at 7:55 A.M., CNA OO said the resident would be left alone in his/her room and be heard yelling and cursing from the hall. The resident's bed was against the wall and the resident would bang on the wall. The resident was always upset, and he/she wanted to smoke all the time. If you told the resident it wasn't time to smoke, he/she would get even madder. The resident was difficult to communicate with, and CNA OO would try to verbally calm the resident down. CNA OO always told the nurses about his/her behaviors and was not aware of interventions in place that kept him/her from biting his/her fingers. During an interview on 04/20/26 at approximately 12:00 P.M., the Social Service Director said she did not know the resident well and had only been working at the facility for about one month. During an interview on 04/20/26 at 12:33 P.M., Wound Nurse NN said it was reported that the resident always was chewing his/her right hand dressing off. The resident was admitted without an index finger to his/her right hand. The resident was frequently left alone in his/her room when he/she visited the resident. Wound Nurse NN was not aware of any special intervention for staff to monitor the resident. The resident was always heard yelling and cursing from his/her room. During an interview on 04/20/26 at 2:45 P.M., CNA JJ said the resident could raise his/her arms and chew on the dressings that were on the right hand. The resident had frequent outbursts. The resident would get mad if there were no cheese on his/her eggs, and he/she would strike his/her head with his/ her arms and start cursing at the staff. Everyone knew about the resident's behavior. CNA JJ would have the resident sit in the hall near the nurses' station. If CNA JJ saw the resident bite his/her hand or try to hit him/herself in the head, CNA JJ would try to intervene and stop the resident. There were no special interventions in place for the resident's self-mutilation. The resident was not on 1:1 or frequent checks. During an interview on 04/21/26 at 5:25 A.M., LPN I said he/she was aware the resident had bit his/her fingers previously. Nursing staff should document all behaviors that the residents have, and notify the psychiatrist and primary physician of ongoing behaviors. LPN I was aware he/she did not have very good documentation of the resident's behaviors. The resident needed stronger medication to stabilize his/her moods. LPN I did not reach out to the psychiatrist when the resident had his/her outbursts because the resident was always difficult to deal with, and his/her behaviors were nothing new. During an interview on 04/22/26 at 11:42 A.M. the Social Service Designee said when the resident was first admitted to the facility, not much was known about him/her. After a couple of weeks, they had to send him/her out because he/she was nibbling on his/her fingers. When he/she came back, the finger was wrapped. The resident does not like to talk to people. She did not know what the residents' [TRUNCATED]

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was served to residents at a safe and palatable temperature, affecting six out of 33 sampled residents (Residents #3, #5, #12, #78, #110, and #148). The census was 149. Review of the facility's dietary food preparation policy, dated 7/5/23, showed:-Food Temperatures: Foods will be served at proper temperature to ensure food safety;-If temperatures do not meet acceptable serving temperatures, reheat the product or chill the product to the proper temperature;-Warm foods should measure at 135 degrees Fahrenheit (F). 1. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/1/26, showed:-Diagnoses included type two diabetes;-Cognitively intact. During an interview on 4/20/26 at 7:27 A.M., the resident said the food tasted terrible and was always cold. 2. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Diagnoses included chronic kidney disease;-Moderately impaired cognition. During an interview on 4/19/26 at 10:43 A.M., the resident said food was most always cold when it was delivered to him/her. 3. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Diagnoses included anorexia (eating disorder);-Cognitively intact. During an interview on 4/19/26 at 9:22 A.M., the resident said the food was most always served cold. He/She said he/she had an eating disorder, and it did not help that the food was cold, which made him/her not want to eat it. 4. Review of Resident #78's quarterly MDS, dated [DATE], showed:-Cognitively intact. During an interview on 4/19/26 at 8:57 A.M., the resident said the food was served cold a lot of the time. 5. Review of Resident #148's quarterly MDS, dated [DATE], showed:-Moderately impaired cognition. During an interview on 4/20/26 at 8:48 A.M., the resident said the food could sometimes be cold. 6. Observation on 4/19/26 at 9:01 A.M., of the 300 south hallway breakfast, showed:-Breakfast was served in Styrofoam boxes;-Sauage patty measured 81.5 degrees Fahrenheit (F) and was cold;-Scrambled eggs measured 80.7 degrees F and were cold;-Cream of wheat measured 118 degrees F and was cold. Observation on 4/20/26 at 12:01 P.M., of the 200 hallway lunch, showed:-The room tray cart was uncovered and the plates had no coverings;-Pasta with meat measured 120 degrees F and was lukewarm;-Mixed veggies measured 108 degrees F and were cold. 7. During an interview on 4/24/26 at 7:29 A.M., the Regional Certified Dietary Manager said he would expect food to be delivered to residents at a safe and palatable temperature. He would expect staff to return food to the kitchen if it was too cold. 8. During an interview on 4/24/26 at 10:32 A.M., [NAME] O said the facility policy was to deliver food to the residents at a safe and palatable temperature to avoid sickness. 9. During an interview on 4/24/26 at 10:45 A.M., the Administrator said she would expect food to be delivered to residents at a safe and palatable temperature. 28058152978916

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the pest control program was effective in preventing mice, which affected three out of 33 sampled residents (Residents #48, #12, and #78). The census was 149. Review of the facility's pest control program policy, dated 5/14/24, showed:-Purpose: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents;-Policy: Facility will maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services on a regular and scheduled basis. Facility will ensure that appropriate chemicals are used to control pests but can be used safely inside the building without compromising resident health. Facility will maintain a report system of issues that may arise in between scheduled visits with the outside pest service and treat as indicated. Facility will utilize a variety of methods in controlling certain seasonal pests, i.e. flies. These will involve indoor and outdoor methods that are deemed appropriate by the outside pest service and state and federal regulations. Facility will ensure that the outside pest service also treats the exterior perimeter of the facility and any outlying buildings or structures, i.e. dumpster area, etc. Review of the facility's pest control logs showed on 4/15/26, 4/8/26, 3/31/26, 3/25/26, and 3/19/26, the facility was treated by the pest control company and mouse traps were replaced. 1. Review of Resident #48's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/10/26, showed:-Diagnoses included schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), chronic pain syndrome, and mild intellectual disabilities;-Moderately impaired cognition. During an interview on 4/24/26 at 1:16 P.M., Licensed Practical Nurse (LPN) D and Certified Nursing Assistant (CNA) B said housekeeping staff hours were cut when the new ownership took over the facility. They said the current housekeepers did not clean the resident rooms as frequently as they should. They said there was a mouse problem and indicated that the resident's room is where mice were seen the most. CNA B said the resident did not like people going through his/her things, so his/her belongings did not get cleaned. Observation and interview on 4/24/26 at 1:29 P.M., showed the resident sat on the edge of his/her bed. A squeaking noise could be heard near the resident's dresser. A mouse trap behind the resident's dresser had a live mouse in it. The clothing in the resident's bottom drawer had brown sprinkle shaped substance on them. Food and trash wrappers were in the drawer. The resident said mice were always around his/her room and crawled on him/her at night. During an interview on 4/24/26 at 1:25 P.M., Maintenance FF came into the room to dispose of the mouse and said the resident's room was a hotspot for mice due to the resident's belongings not being cleaned. 2. Review of Resident #12's quarterly MDS, dated [DATE], showed:-Diagnoses included anorexia, bipolar disorder (mood disorder that causes mood swings), post-traumatic stress disorder (PTSD), and major depressive disorder;-Cognitively intact. Observation and interview on 4/20/24 at 12:42 A.M., showed the resident's room had brown sprinkle shaped matter in the closet. The resident said he/she had seen mice in his/her room. He/She said most recently two mice were caught in the glue trap in his/her room. 3. Review of Resident #78's quarterly MDS, dated [DATE], showed:-Diagnoses included paranoid schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), anxiety, and insomnia;-Cognitively intact. During an interview on 4/19/26 at 8:57 A.M., the resident said there were mice all over the place on the 300-south hallway. He/She said he/she had seen mice in the hallway. 4. Observation on 4/24/26 at 9:44 A.M., of the 300-south hallway, showed a mouse ran across the floor and into the medication storage room. CNA B said there were mice all over and pointed out mouse droppings on the floor, in the corner of the medication storage room. 5. During an interview on 4/24/26 at 11: 18 A.M., Pest Control Technician P said his/her company came out every week to treat the facility. He/She said the company was focusing on mice. He/She said they had gone from catching 30 mice a week to 10 a week. He/She said the facility had been recommended to (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	keep resident rooms clean and free from food trash to avoid mice. He/She said the mouse traps had a 30-day life span before they needed to be replaced. 6. During an interview on 4/24/26 at 4:20 P.M., the Administrator said she would expect facility staff and maintenance staff to follow the recommendations from the pest control company to deter mice. She would expect staff to inform her and the Maintenance Director if they were seeing mice or mouse droppings. She would expect staff to assist residents in keeping their rooms free from food trash. 29838892805815