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	04/28/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review, the facility failed to ensure allegations involving abuse were reported within the required two-hour time frame, following a resident-to resident altercation, resulting in an injury (Resident #131). The sample size was 15. The census was 149. Review of the facility's Abuse and Neglect Policy, revised 6/12/2024, showed:-It is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames;-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. Review of Resident #131's quarterly MDS (Minimum Data Set, a federally mandated resident assessment instrument), dated 4/6/26, showed:-The resident is cognitively intact;-Medical diagnoses including dyskinesia (a movement disorder characterized by involuntary, erratic, and uncontrollable muscle movements like writhing, fidgeting, or head bobbing), tinea unguium (onychomycosis, a contagious fungal infection of the nail bed, typically caused by dermatophytes, leading to thickened, yellowed, brittle, or crumbling nails), and schizophrenia (a chronic, severe brain disorder affecting thinking, emotions, and behavior, often involving hallucinations, delusions, and disorganized speech). Review of the resident's progress notes, showed:-A note from 4/27/26 at 1:00 A.M. indicating the nurse on the floor had noted the resident to be at the door of his/her room calling for help from the nurse. A large amount of blood was coming from two lacerations to the resident's forehead, who reported the resident's roommate hit him/her with a trashcan. The residents were separated by staff, and both were sent to the hospital for evaluation;-A note from 4/27/26 at 7:58 A.M. indicating the resident had returned from the hospital for evaluation with dissolvable stitches to both forehead lacerations. Review of the facility's submitted report of the incident, showed the report was submitted on 4/27/26 at 2:01 P.M. Review of the facility's Incidents and Accidents report, dated 4/21/26 through 4/28/26, showed the incident between Resident #131 and the other resident listed as occurring on 4/27/26 at 1:15 A.M. During an observation and interview on 4/28/26 at 9:21 A.M., the resident said on the evening of 4/26/26, a resident attacked him/her while asleep in bed. The resident woke up to the resident screaming and swinging at him/her with a trash can. Resident #131 was struck at least twice with the trash can before he/she was able to leave the room and contact staff for help. Staff immediately separated the residents and provided emergency treatment to two lacerations to the resident's head. During observations, two lacerations, each measuring approximately four inches long, were noted to the resident's forehead with stitches in place to both lacerations. During an interview on 4/28/26 at 10:53 A.M., the Administrator said the incident was reported to her when it occurred early in the morning on 4/27/26 around 1:00 A.M. The Administrator said she had fallen back asleep after receiving the call and missed the two-hour reporting timeframe. The Administrator expected all allegations of abuse resulting in injury to be reported to Department of Health and Senior Services DHSS as required by state and federal regulations. 29957632994684

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