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	05/14/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not follow their policy when Resident #161signed out of the facility, did not return, and the facility failed to initiate a Code Purple (missing person) per policy. The resident's guardian did not give permission for the resident to sign him/herself out. Per facility policy, when the resident failed to return to the facility for dinner and evening medications and did not return all night, staff should have initiated a Code Purple. The resident signed out at 3:55 P.M. on 05/08/26 to go outside, with no expected return time listed. Staff found the resident's wheelchair outside and could not locate the resident. Staff did not document attempts to locate the resident from 05/08/26 through 05/11/26 and did not document their communication with law enforcement. Per the resident's hospital records, the resident arrived in the emergency room (ER) on 05/11/26 at 8:20 P.M. and said he/she had been assaulted and was experiencing right ring finger pain and a broken nail. The resident tested positive for marijuana and cocaine. The sample was seven and the census was 145. Review of the facility's Elopement and Wandering Residents policy, revised 06/12/24, showed: -Purpose: The facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care;- Elopement occurred when a resident left the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so;- The facility was equipped with door locks/alarms to help avoid elopements;-Alarms were not a replacement for necessary supervision. Staff were to be vigilant in responding to alarms in a timely manner;-The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary;- Residents were assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team;-The interdisciplinary team evaluated the unique factors contributed to risk and developed a person-centered care plan;-Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards were added to the resident's care plan and communicated to appropriate staff;-Any staff member becoming aware of a missing resident alerted personnel using facility approved protocol;- Code purple meant elopement outside of facility;-The designated facility staff looked for the resident;-If the resident was not located in the building or on the grounds, the Administrator or designee notified the police department and served as the designated liaison between the facility and the police department.- The Director of Nursing (DON) or designee notified the physician and family member or legal representative;-The police were given a description and information about the resident;-All parties where notified of the outcome when the resident was located;-Appropriate reporting requirements to the state agency would be conducted. Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, dated 06/12/25, showed:-Therapeutic leave meant absences for purposes other than required (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospitalization;-If a resident did not return from therapeutic leave as expected, documentation in the medical record should show evidence the facility attempted to contact the resident and resident representative. The facility's sign-out/leave of absence policy was requested during the entrance conference of the investigation on 5/13/26. During an interview on 05/13/26 at 3:19 P.M., the Administrator said they did not have a sign-out/leave of absence policy. Review of Resident #161's Electronic Medical Record (EMR), showed:-admitted [DATE] from a skilled nursing facility;-Cognitively intact;-Diagnoses included diabetes, bipolar disorder (a mental health condition characterized by extreme, shifts in mood, energy, and activity levels), schizophrenia (a chronic brain disorder that cause people to interpret reality abnormally), chronic respiratory failure, personality disorder (mental health condition characterized by rigid, inflexible patterns of thinking, feeling, and behaving), intellectual disabilities (a neurodevelopmental condition characterized by significantly below-average intelligence alongside major deficits in adaptive daily living skills) and muscle weakness. Review of the resident's PASSR Level II evaluation, dated 01/12/26, showed:-The resident's parent was his/her legal guardian and his/her sibling was the co-guardian;-Previous level II completed in 2020 showed an extensive history of psychiatric issues and substance use with numerous hospitalizations. Behaviors included outburst, poor impulse control, periods of increased anxiety and agitation. Displayed inappropriate expression of feelings with ineffective problem solving. He/She engaged in high-risk behaviors and displayed poor decision-making skills with some attention seeking behavior. The resident eloped from the hospital in 2020-The resident's needs could be met at a nursing facility;-The facility provided a behavior support plan, structured environment (provided personal space, gave instructions at the resident's level of understanding and established a consistent routine), and personal support network;-Environmental supports to prevent elopement was blank. Review of the resident's EMR showed no admission paperwork from the transferring nursing home. Review of the resident's EMR showed the resident's admission minimum data set (MDS), a federally mandated assessment completed by facility staff was in progress. Review of the resident's elopement evaluation, dated 05/05/26, showed no identified risk of elopement. Review of the resident sign-out log, dated 05/08/26, showed:-The resident signed out at 3:55 P.M. to go outside;-The resident provided a contact number;-Sign in time was blank. Review of the resident's care plan in use during the survey, showed:-Problem: The resident was noncompliant with the facility sign-out policy. On 05/08/26 left the facility without proper authorization/safety measures (date initiated: 05/08/26);-Interventions: Staff reinforced importance of signing out appropriately, educated the resident on the facility sign-out policy and safety concerns of leaving the facility (date initiated: 05/10/2026). Review of the resident's progress notes, showed:-On 05/09/26 at 12:22 A.M., Licensed Practical Nurse (LPN) F noted the resident signed him/herself out of the facility. Staff were not aware. He/She said he/she was going with his/her boyfriend. The resident left his/her wheelchair in the front of the building. At 12:24 A.M., the resident's power of attorneys (POA) were notified. At 12:52 P.M., LPN A noted the resident did not return to facility on his/her shift. The resident's guardian requested a call every shift with updates on the resident's status;-There was no documentation of attempts to locate the resident, any contact with law enforcement, or updates to the guardian each shift as requested. Review of the resident's care plan in use during the survey, showed:-Problem: The resident had bipolar disorder (date initiated: 05/10/2026);-Interventions: Staff monitored mood, behaviors, sleep patterns, and changes in mental status, observed for signs of depression, mania, agitation, impulsiveness, or anxiety, administered psychotropic medications as ordered and monitored for side effects;-Problem: The resident had diabetes (date initiated: 05/10/26);-Interventions: Staff monitored blood glucose levels as ordered and reported abnormal results to the physician and administered diabetic medications/insulin as prescribed;-Problem: The resident had schizophrenia (date initiated: 05/10/2026);-Interventions: Staff assessed for suicidal ideation, aggression, or self-harm behaviors, administered antipsychotic medications as ordered and monitored for effectiveness and side effects; Review of the resident's medication administration report (MAR), (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated May 2026, showed on 05/09/26, 05/10/26 and 05/11/26 all medications were documented with a 1 (absent from home without meds).-Aripiprazole (antipsychotic medication) oral tablet 20 milligrams (mg). Give 1.5 tablet by mouth once a day, at 9:00 A.M. for depression. Staff documented a 1 (absent from home without meds) on 05/09/26, 05/10/26 and 05/11/26;-Spironolactone (used as a potassium-sparing diuretic (water pill)) oral tablet 25 mg. Give one tablet by mouth once a day, at 9:00 A.M. for high blood pressure. Staff documented a one on 05/09/26, 05/10/26 and 05/11/26;-Carbamazepine (used to control certain types of epileptic seizures, manage bipolar disorder, and relieve nerve pain) oral tablet 200 mg. Give one and a half tablet by mouth twice a day, at 9:00 A.M. and 5:00 P.M. for major depressive disorder. Staff documented a one on 05/09/26, 05/10/26 and 05/11/26;-Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated (used as a daily maintenance treatment for asthma and chronic obstructive pulmonary disease (COPD))100-50 micrograms. One inhalation orally twice a day, at 9:00 A.M. and 5:00 P.M. for COPD. Staff documented a one on 05/09/26, 05/10/26 and 05/11/26. Review of the resident's hospital record, dated 05/11/26, showed:-The resident arrived at the ER on [DATE] at 8:20 P.M. via ride share;-The social worker documented Missouri court records showed guardianship was established in 2020;-The resident arrived for right ring finger pain and a broken nail. The resident said he/she was pushed and did not want to talk about it. The resident said he/she left his/her nursing home a few days prior due to safety concerns. He/She was not happy with the care received at the nursing home. He/She stayed with a friend. ER staff contacted the resident's guardian;-The resident's guardian said the resident eloped from the nursing home on [DATE]. He/She was not notified when the resident signed out of the facility. He/She was concerned about the resident's missed medications and for his/her safety. The resident did drugs when he/she was in the streets. The resident solicited people on social media for sexual behaviors. The facility said they were not aware the resident had a guardian and needed to be on a locked unit. The facility said they filed a missing person report with the police department;-The hospital social worker spoke with the resident. The resident confirmed he/she was assaulted. He/She said he/she walked outside at night and did not know where he/she was. He/She was close to the ER because the ride was about five minutes. The resident did not know the perpetrator's name. The resident said Alternatives to Living in Violent Environments (ALIVE) (non-profit organization that provides counseling, emergency sanctuary, and critical support services to adults impacted by domestic and intimate partner violence) provided the ride to the ER;-The hospital contacted the police department because the resident's guardian told them the facility said they filed a missing person's report. They called the police to verify the information. They did not have a missing person report on file. They arrived at the ER and spoke to the resident about the assault allegation. The resident refused to cooperate or answer questions;-The resident's urine drug screen was positive for marijuana and cocaine;-X-rays of the resident's right hand were negative for new fractures;-Discharge diagnoses were bizarre behavior, schizophrenia and diabetes;-The resident was discharged back to the facility on [DATE] with a new order for placement on secured unit. Review of the resident's progress notes, showed:-On 05/12/26 at 9:21 P.M., the resident was readmitted to the facility from the hospital. The resident's diagnosis was pain in the finger. The resident arrived via ambulance. He/She was alert and oriented. The resident was moved to the secured unit due to elopement risk. Staff initiated location monitoring. The resident's physician and guardian were notified of resident's return. Review of the resident's elopement evaluation, dated 05/12/26 at 9:25 P.M., showed:-The resident had a history of elopement;-The resident did not wander;-A risk for wandering/elopement was identified;-No interventions or clinical suggestions were selected. Review of the resident's care plan in use during the survey, showed no documentation of the resident's elopement risk and interventions. Review of the facility's investigation not dated, showed:-A copy of the resident sign-out log for 05/08/26;-Incident report dated 05/08/26 at 9:00 P.M.;-Incident description: The resident signed him/herself out of facility against facility policy. Unable to give description of resident. The incident was unwitnessed;-Immediate action taken: The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's physician (05/08/26 at 10:34 P.M.), responsible party (05/08/26 at 10:35 P.M.), and police (no time or date noted) were notified;-Predisposing physiological signs: Non-compliance;-A handwritten note (not dated or signed) read the administrator said she informed the resident's physician he/she signed out. The physician said the resident would be okay;-No summary, staff statements, in-services or conclusion were included in the incident report. Observation on 05/14/26 at 10:01 A.M., showed the resident propelled throughout the secured unit. He/She refused to answer any questions. During an interview on 05/14/26 at 12:05 P.M., LPN A said he/she worked on the first floor from 7:00 A.M. to 3:00 P.M. on 05/08/26 and 05/09/26. He/She was notified on 05/09/26 the resident signed out on 05/08/26 and did not return. LPN F told him/her the resident's guardian was notified, and all protocols were followed. If the resident had returned during his/her shift, he/she would have documented it. If a resident does not return by midnight, staff should notify the responsible party, DON and Administrator. He/She did not know what determined if law enforcement should be called. Residents with guardians had to have permission to sign out. They could go to appointments or sit outside with a staff escort. All residents had to stop at the front desk to sign out. The receptionist was supposed to get report before allowing a resident to sign out. During an interview on 05/14/26 at 12:23 P.M., Certified Nursing Assistant (CNA) B said he/she usually worked the day shift, on the first floor. He/She worked the day shift on 05/08/26 and evening shift on 05/09/26. He/She was assigned to the resident both days. Staff were supposed to do rounds every one to two hours. On 05/08/26, he/she saw the resident earlier in the day. At 2:45 P.M., he/she told the nurse the resident went downstairs and did not return to the floor. He/She did not see the resident around dinner time. LPN F looked for the resident. LPN F said he/she would check the sign-out log. CNA B told LPN F the resident had a guardian. Staff searched inside and outside the building. They could not locate the resident. He/She was not sure what LPN F did after they could not locate the resident. CNA B continued to assist other residents. He/She did not see the resident on 05/09/26. Residents were supposed to return to the facility by 10:00 P.M. If a resident did not return from leave of absence (LOA), he/she notified the nurse and followed their direction. During an interview on 05/14/26 at 12:58 P.M., Receptionist E said he/she was the receptionist for a month. He/She usually worked from 7:00 A.M. to 3:00 P.M. Another receptionist worked from 3:00 P.M. to 7:00 P.M. The other receptionist was out sick. They also had receptionists that worked as needed. He/She was not at work when the resident signed out and did not return. He/She was told the resident could leave as long as he/she signed out. He/She did not remember who said the resident could sign out. The residents could not leave after 8:00 P.M. There was always someone at the front desk. The front door was always locked. Someone had to let the residents in and out. There was not a list at the front desk to show which residents had a guardian. He/She asked the Administrator or medical records clerk if the residents could sign out. During an interview on 05/15/26 at 9:27 A.M., LPN F said the resident signed out to go outside on 05/08/26. The resident told the receptionist he/she was his/her own responsible party. The resident was gone for a long time. He/She did rounds at 11:30 P.M. Residents were supposed to return to the facility by midnight. The resident did not return. He/She looked for the resident inside the facility. He/She called the resident's guardian at 11:00 P.M. or 11:30 P.M. on 05/08/26. He/She notified the DON, Administrator and physician when he/she realized the resident was not allowed to sign out. He/She was instructed to call the police. The police arrived and took LPN F's information. The police gave him/her a police report number. He/She tried to contact the resident. The number the resident provided did not work. He/She did not have a car and could not go look for the resident. LPN F arrived for his/her shift on 05/09/26 and was informed the resident still had not returned to the facility. The Administrator said the resident signed out against medical advice and it was not elopement. LPN F was told a man picked the resident up. He/She did not know the resident had a guardian until he/she eloped. He/She had never worked with the resident before. The facility did not provide information on new admits. The facility did not tell staff assigned to the first floor which residents had a guardian. He/She assumed if the resident was (continued on next page)

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