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	07/16/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46888 Based on observation, interview, and record review, the facility failed to ensure a resident was assessed and demonstrated the ability to safely self-administer medications when the resident self-administered medications via a gastric tube (g-tube, tube surgically inserted into the stomach to administer food, fluid, and nutrition) and did not follow acceptable standards of practice. Staff present at the time failed to provide education on safe medication administration as the medications were being administered (Resident #45). The census was 151. Review of the facility's Medication-Self Administration policy, dated 10/24/22, showed: -Policy: Residents who request to perform medication self-administration will be assessed for capability. The assessment of medication self-administration will ensure a clinically appropriate, effective process for the resident to provide self-care. The facility is responsible to ensure medications are administered as ordered by the attending physician even when self-administered; -Procedure: During the admission process, residents will be asked if they wish to self-administer medications; -Those residents who wish to self-administer medications will be assessed during the admission process to ensure they have the necessary knowledge and skill(s) to safely self-administer medications; -Additional assessments will be completed at least quarterly; -Based on clinical judgment, a licensed nurse may reassess a resident related to the safe self-administration of medications as needed; -The resident must be able to demonstrate the following: -Knowledge of medications and medication schedule; -The ability to read the medication label and manufacturer's insert; -Self-administration techniques including use of packaging, reading label, opening containers; -Ability to administer medication properly, e.g., insulin/syringe, eye drops, inhalers; (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Agree to comply with facility policy related to the self-administration of medication; -If the resident is assessed as clinically appropriate for medication self-administration, by the Interdisciplinary Team (IDT), the licensed nurse obtains a physician's order for self-administration of selected medications; -The resident's record should contain documentation that demonstrates that he/she was part of the IDT process in determining whether self-administration is safe and appropriate; -Medications specifically excluded from self-administration for any reason must be specified in the attending physician's order; -Self-administration is only permitted if approved in writing by the attending physician, which may be in the form of an order; -The IDT develops and implements a care plan for medication self-administration; -The care plan will identify: -Where the medications are stored; -Education for resident/family regarding medication self-administration process, specific medication information and safe, effective use of medications; -Obtaining medication; -Administering medication according to physician order; -How licensed nurses will validate that medications are taken as ordered by the attending physician; -How non-compliance and/or refusal to take medications will be managed; -The licensed nurse on each shift ensures that medications are taken as ordered by the attending physician and documents on the medication administration record (MAR); -Residents will be re-evaluated if any member of the IDT suspects non-compliance with the self-administration authorization or any change in the resident's cognitive status; -In the case of suspected medication non-compliance (e.g. dosage in excess of the amount anticipated, loss of therapeutic control or suspected drug toxicity) the nursing staff will complete an assessment. The attending physician will be notified if the resident is no longer deemed appropriate for self-medication administration. The licensed nurse will obtain orders as necessary; -Documentation: The physician's order approving the self-administration of medication will be maintained in the resident's medical record; -The Assessment for self-Administration of Medications will be maintained in the resident's chart; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Self-administration of medications will be documented in the resident's care plan and the MAR. Review of Resident #45's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 4/26/24, showed the following: -Diagnoses included severe protein-calorie malnutrition (inadequate intake of food containing calories and proteins), bipolar (mental disorder that affects a person's thoughts, feelings, and behaviors), depression, post-traumatic stress disorder (a past event that affects a person's thoughts, feelings, and behaviors) and anxiety; -Feeding tube used; -Cognitively intact. Review of the resident's care plan, dated 6/11/24, showed: -Focus: resident has declined to allow staff to administer his/her medication via oral route as directed; -Goal: resident will have his/her medications administered as directed; -Interventions: encouragement and retraining needed to allow resident to regain taste sensation of medication, monitor his/her intake of medications, if nausea/vomiting persists administer his/her medications via Peg Tube (a type of feeding tube) and document. Review of the resident's physician order sheet, in use at the time of the survey, showed: -An order dated 1/6/24, for staff to flush the enteral tube (feeding tube) with 30 milliliters (ml) of water before and after medication administration. Flush with 5-10 ml water between medications; -An order dated 5/17/24, for g-tube site care every shift; -An order dated 6/11/24, for staff to make a slurry of his/her medications; -An order dated 6/27/24, for Protonix (treats acid reflux) delayed release, 40 milligrams (mg) via g-tube daily; -No order to self-administer medications. Review of the resident's progress notes, dated 7/8/24 at 11:43 A.M., showed the resident requested to self-administer medication through the g-tube. Staff made medical director (MD) aware. MD said decline to give order and stated that nurse must give resident his/her medication. The resident and Director of Nursing (DON) made aware. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/11/24 at 7:30 A.M., showed Licensed Practical Nurse (LPN) J prepared medications for the resident at the nurse's station. He/She crushed the resident's Protonix tablet and placed the resident's medication into a 5 ml medication cup and walked to the resident's room. LPN J filled a graduate (container used to measure liquids) with warm water from the sink in the resident's room, added an unmeasured amount to the medication cup, and handed the resident the cup of fluid containing medications. The resident exposed his/her abdomen and produced the g-tube, removed the stopper and inserted an empty syringe in the g-tube, the plunger remained on the bedside table. The resident poured approximately half of the liquid containing medication into the syringe, a large amount of air remained in the syringe, placed the plunger at the end of the syringe and then pushed the liquid containing medications in quickly and with force, approximately 9 cc of air also injected into the stomach. The resident removed the syringe from the g-tube slightly to allow the plunger to be removed without resistance. The resident placed the syringe back into the g-tube, poured more of the fluid containing medication into the syringe, a large amount of air remained in the syringe, inserted the plunger, and pushed the medications in quickly and with force. The resident removed the syringe from the g-tube slightly to allow the plunger to be removed without resistance. The resident then poured water from the graduate into the cup containing residual medications. The resident placed the syringe back into the g-tube, poured the remaining fluid in the medication cup, a large amount of air remained in the syringe, inserted the plunger, and pushed the medications in quickly and with force. The resident replaced the stopper and laid back into bed. LPN J observed the resident administering medication, did not cue the resident to allow the medication to be administered via gravity, did not cue the resident to not to push air into the stomach, and did not provide education on the risks of inserting air into the stomach. During an interview on 7/11/24 at 8:47 A.M., LPN J said the resident will not allow staff to flush, administer the medication, or apply the gauze to the g-tube site. The resident has a history of refusing the medications if staff attempt to provide medications and treatments as ordered. The resident needs constant reminders to not push so much air into the stomach while administering the medications. The resident's medications that are in pill or capsule form, staff opens the capsules and crushes the contents along with the pills. During an interview on 7/11/24 at 3:14 P.M., Pharmacist Y, a pharmacist with the pharmacy which supplies the facility's medications, said the Protonix is not to be crushed and the facility should have contacted the pharmacy for a liquid form of the medication. During an interview on 7/15/24 at 2:53 P.M., LPN U said only the nurses should administer the medication through a g-tube. When the resident has an order to self-administer medications through a g-tube, the nurse should remain with the resident during administration and remind the resident about the steps. During an interview on 7/16/24 at 12:14 P.M., the DON said a resident should have an order to self-administer medication and fluids through a g-tube. She expected staff to document refusals and to notify nursing management and the doctor. She expected staff to observe a resident self-administering their medications, and cue the resident as needed. She was unaware the Protonix was being crushed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 40290 42795 Based on observation, interview and record review, the facility failed to provide reasonable accommodation of needs and preferences by failing to ensure three residents had wheelchairs that were in good condition and properly fit the residents (Resident #1, #87, and #127). The facility also failed to provide side rails to assist one resident with bed mobility, positioning, and transfers (Resident #42) and ensure one resident had his/her call light in reach (Resident #89). In addition the facility failed to provide access to community rooms on the third floor, therefore limiting access for the residents to the TV and vending machines for three residents (Resident #46, #138 and #45). The sample was 30. The census was 151. Review of the facility's Admission Packet, revised 7/2022, showed the facility shall offer personal care, room, board, dietary services and laundry services. The facility will also offer nursing care, activities, restorative and rehabilitative services, and psychosocial care as identified in the resident's plan of care established by the facility to the extent required by the facility standards and in accordance with the policies of the facility. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/23/24, showed: -Cognitively impaired; -Functional limitations of range of motion (ROM): Impairment to left upper extremity and to both lower extremities; -Uses a manual wheelchair; -Diagnoses include aphasia (difficulty speaking) and traumatic brain injury (TBI). Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has an activity of daily living (ADL) self-care performance deficit related to hemiparesis (muscle weakness to one side of the body) to left side; -Interventions: The resident requires assistance of one staff member for long distance in his/her wheelchair; The resident requires assistance to reposition his/herself while in his/her wheelchair; The resident requires extensive assist of two staff members with transfers, bed mobility, dressing, grooming, personal hygiene and oral care. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 7/8/24 at 8:53 A.M., 7/9/23 at 11:05 A.M. and 7/12/24 at 9:30 A.M., showed the resident sat in a manual wheelchair. The resident had a large, thick, gray supportive arm rest positioned under his/her contracted left arm. Where the resident's elbow was positioned on the arm rest, a large hole was present. The arm rest material that resembled vinyl had multiple splits and tears on it. The resident said he/she liked the arm rest and said it would be nice to have one that didn't look so bad and felt more comfortable. The right arm rest on the wheelchair was made of metal and a bright green, worn-through plastic cover that was held together with duct tape. He/She said the arm rests had a been like that for months. During an interview on 7/12/24 at 8:40 A.M., Certified Nursing Assistant (CNA) RR said the resident's wheelchair arm had been like that for a several weeks. He/She did not know if the issue had been reported to anyone. CNAs on night shift were responsible for cleaning the wheelchairs and informing the appropriate persons for any repairs or issues with the wheelchairs. During an interview on 7/12/24 at 8:50 A.M., Licensed Practical Nurse (LPN) L said the resident's arm rest had been like that since January, 2024. Everyone was aware of it including therapy, but nothing has been done. During an interview on 7/15/24 at 10:15 A.M., Occupational Therapist (OT) UU said the resident's supportive arm rest had just been reported to him/her last week and it has to be special ordered. The resident has left sided arm weakness and requires his/her arm to be supported for comfort and mobility. She would expect staff to notify the therapy department when assistive devices are damaged or non-functional. 2. Review of Resident # 87's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Uses wheelchair; -Independent with propelling self 50 feet and making two turns; -Independent with propelling self 150 feet in a corridor or similar space. Review of the resident's face sheet, undated, showed diagnoses that included: Pain in right and left leg, spinal stenosis (narrowing of the spinal canal causing pain), difficulty walking, iliotibial band syndrome (a painful condition in which connective tissue rubs against the thigh bone). Observation and interview on 7/10/24 at 8:31 A.M., 7/12/24 at 8:50 A.M., and 7/15/23 at 9:55 A.M., showed the resident sitting in his/her wheelchair with his/her shoulders forward, self-propelling in the hallway. The resident's knees were positioned above his/her waist and the resident made short, shuffled movement with his/her feet. The resident said the wheelchair was too small for him/her. He/She said his/her bottom, legs and knees hurt while he/she was in the wheelchair. The resident said he/has had the wheelchair for several months. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/24 at 8:50 A.M., LPN L said the resident has had the wheelchair for several months. The wheelchair looked like it didn't fit the resident correctly. Therapy was responsible for wheelchairs fittings. A physician order was not needed for wheelchair adjustments. The resident does complain of knee and back pain. The nurse wasn't sure if therapy was informed. During an interview on 7/11/24 at 10:00 A.M., OT VV said he/she did not think the wheelchair fit the resident correctly. The wheelchair seat needed to be taller. Assessments of the wheelchairs can be completed without a physician order by the therapy department. A properly fitting wheelchair would provide comfort and better mobility for the resident. 3. Review of Resident #127's quarterly MDS, dated [DATE], showed: -Room on second floor of facility; -Moderate cognitive impairment; -Independent with use of manual wheelchair; -Diagnoses included cognitive communication deficit, depression, anxiety, generalized muscle weakness, other reduced mobility, muscle wasting and atrophy, and unspecified lack of coordination. Observation on 7/8/24 at 10:28 A.M., showed the resident seated in a wheelchair in the hallway. The covering on the front of the right armrest torn and split open, leaving approximately four inches of yellow stuffing exposed. During an attempted interview, the resident was unable to respond regarding questions pertaining to his/her wheelchair and comfort. Observation on 7/9/24 at 12:19 P.M., showed the resident sat in his/her wheelchair in the dining room. The right armrest torn had exposed stuffing. CNA E and CNA PP interacted with the resident. Observation on 7/11/24 at 8:40 A.M., showed the resident sat in his/her wheelchair in the hallway, talking to LPN F about pain. The resident wore a t-shirt and his/her right arm rubbed against the torn armrest on the right side of his/her wheelchair. Observation on 7/15/24 at 7:06 A.M., showed the resident sat in his/her wheelchair with the right armrest torn and stuffing exposed. During an interview on 7/15/24 at 2:48 P.M., CNA R said CNAs clean wheelchairs every day after the resident has laid down. He/She has seen the torn armrest on the resident's wheelchair. When asked if he/she reported this to anyone, CNA R said people probably know. But CNA R did not 4. During an interview on 7/16/24 at 7:40 A.M., the Wound Nurse said CNAs and any staff who interact with the residents should notice if a resident's wheelchair has a torn armrest. Issues with wheelchairs should be reported to Maintenance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 7/16/24 at 10:24 A.M., the Regional Maintenance Director said they have a process to where the facility staff can place a request for wheelchair repairs in the TELS Platform (a web based technology designed to assist with building operations). They currently do not have an audit system in place to routinely check resident wheelchairs that are in use. He would expect staff that were completing the weekly wheelchair cleanings to report any damaged wheelchairs that need repair. 6. Review of Resident #42's quarterly MDS, dated [DATE], showed: -No cognitive impairment; -Diagnoses include heart failure, high blood pressure, asthma, respiratory failure; -Receives oxygen therapy; -Uses wheelchair. Review of the resident's Physician's Orders Sheet (POS), dated July 2024, showed an order, dated 4/26/24, side rails 1/4 for positioning, bed mobility, and transfers. Review of the resident's side rail assessment, dated 5/24/24, showed: -Recommendations: Bed rails are indicated and serve as an enabler to promote bed mobility and independence; -If bed rails are indicated, please specify: Bilateral; -The resident understands the positive and negative aspects of bed rail use and are aware of risks involved with bed rail use: Yes. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has an ADL self-care performance deficit related to rheumatoid arthritis; -Goal: Will maintain current level of function in ADLs; -Interventions: Side Rails: 1/4 rails up as per physician's order for safety during care provision, to assist with bed mobility, positioning and transfers. Observe for injury or entrapment related to side rail use. Observation and interview on 7/11/24 at 9:15 A.M., showed the resident was in bed; alert and oriented. The resident did not have side rails on the bed. The resident said he/she was supposed to have them, but did not receive them yet. When he/she wants to reposition him/herself, he/she will reach over and grab the night table or the table that holds his/her television. His/Her old bed had the side rails, but he/she received a new bed. They had an order for the side rails since admission and he/she was assessed for it. He/She was waiting for the side rails for the new bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/15/24 at 11:55 A.M., and 7/16/24 at 8:28 A.M., showed the resident did not have side rails on the bed. During an interview on 7/16/24 at 10:24 A.M., the Regional Director of Plant Operations said if a resident was ordered side rails, central supply would be able to order it and maintenance would install them. He would have to check on the status of the resident's side rails. At 10:54 A.M., he/she said the most recent work order for the resident was on 6/27/24. It was to put the new bed together. There was no work order for the side rails. The MDS Coordinator had the order for the side rails, but maintenance was not aware of it until today, and the side tails will be installed today. When there is an order for side rails in the electronic medical record, it automatically triggers it in TELS. It is instant and he would have known to install the side rails. During an interview on 7/16/24 at 11:18 A.M., the Administrator said she would expect side rails to be ordered and installed as ordered. If a resident received a new bed, she would expect the new side rails to have been ordered at that time. 7. Review of Resident #89's annual MDS, dated [DATE], showed: -No cognitive impairment; -Diagnoses included heart failure, high blood pressure, diabetes, malnutrition, anxiety, bipolar (disorder associated with mood swings ranging from depressive lows to manic highs), and asthma; -Receives oxygen. Review of the resident's care plan, in use during survey, showed: -Focus: Resident is at risk for falls. Gait/balance problems, incontinence, and psychoactive drug use; -Interventions: Educated resident to use call light and to request assist of staff for transfers. Verbalized understanding; -Education provided to use call light for assistance when feeling weak and needing assistance with his/her transfers. Observation and interview on 7/8/24 at 9:39 A.M., showed the resident in bed, calling out for help. He/She sat up in bed, attempted to get up, but was unsuccessful. The resident said he/she was unable to get up and was not able to hit his/her call light because it was stuck. Observation of the call light showed the cord was wrapped up and underneath the leg of a night table. The resident had active bleeding on his/her abdomen. During an interview on 7/16/23 at 11:16 A.M., the Administrator said she expected call lights to be accessible. Staff should ensure the call light is in reach and not stuck on something or underneath objects. 8. Review of Resident #46's , quarterly MDS, dated , 7/3/24, showed: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderate cognitive impairment; -Diagnoses that included depression and schizophrenia (a mood disorder that distorts reality). Review of the resident's activity quarterly review dated 6/27/24, showed the resident's favorite activity is watching movies. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Requires assistance form staff for meeting emotion, intellectual, physical, and social needs; -Interventions: Ensure that the activities the resident is attending are compatible with known interest and preferences; Establish and record the resident's prior level of activity involvement and interest by talking with the resident. During observation and interview on 7/15/24 at 10:00 A.M., the resident sat in the hallway and he/she said there really wasn't anything to do. He/She really wanted to watch TV but didn't have one of his/her own. The community dining room, where everyone could watch TV, had been locked for at least three weeks. He/She wasn't sure why it was locked but really liked going in the community room to watch TV. 9. Review of Resident #138's, quarterly MDS, dated , 5/9/24, showed: -Cognitively intact; -Diagnoses that included anxiety, depression, and schizophrenia. Review of the resident's activity quarterly review, dated 5/14/24, showed the resident's favorite activity documented as not applicable (NA). Review of the resident's care plan, in use at the time of survey did not address the resident's activities. During an interview on 7/9/24 at 12:05 P.M., the resident said he/she misses going into to the community room to watch TV. The community room has been locked for about three weeks, and the TV in the community was broken by another resident about a month ago. Observations on 7/10/24 at 8:20 A.M., 7/12/24 at 9:35 A.M., and 7/15/24 at 9:55 A.M. showed a locked resident community room on the Third floor Main hall at the end of the hall. During an interview on 7/12/24 at 8:40 A.M., CNA RR said the residents on Third floor Main need a TV to watch. If they don't have a TV in their room, there is no other option for them to watch TV. The residents have just been hanging out in the halls with really no where to sit and socialize. During an interview on 7/9/24 at 12:15 P.M., Certified Medicine Technician (CMT) AA said the community room was the main place the residents could go and watch TV and socialize. The residents really enjoyed being in the community room. The community room has been closed for about two weeks. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/12/24 at 9:35 A.M., the facility Maintenance Director said the community rooms on third floor were locked because it gets too hot in the room for the residents to sit in. On Three Main, the community room had a large flat screen TV mounted on the wall with a cord dangling. The Maintenance Director was unable to power on the television. He was not aware the TV was not working. He would expect staff to let him know that the TV was not working. 10. Review of Resident #45's quarterly MDS, dated [DATE] showed the following: -Diagnoses of anorexia (eating disorder), bipolar disorder, and anxiety; -Cognitively Intact. Review of the resident's care plan, dated 6/11/24, showed: -Focus: The resident wishes to stay long term care; -Goal: Will continue to express satisfaction with living arrangements through review date; -Interventions: Encourage social interactions and participation in activities with other residents. During an interview on 7/8/24 at 4:49 P.M., the resident said the door to the day room area where the tables to eat, television, and vending machines are, is normally locked due to the room being too hot. He/She said they would like to be able to use tables to eat and interact with fell ow residents. Observation on 7/8/24 at 4:30 P.M., 7/9/24 at 9:15 A.M., 7/10/24 at 6:54 A.M., and 7/16/24 at 7:09 A.M. of the third floor showed the door to the day room was locked. During an interview on 7/15/24 at 2:38 P.M., CNA M said the door to the day room has been locked for at least three weeks due to the air conditioning unit being broken and the day room being too hot. He/She said it was not homelike for residents to not have access to communal tables for eating, the television, or vending machines. During an interview on 7/15/24 at 2:47 P.M., LPN L said the door to the day room was locked most of the time due to the temperature in the room. He/She said residents are not able to eat together due to this and have to eat in their rooms. He/She does not consider this homelike or accommodating. 11. During an interview on 7/16/24 at 11:16 A.M., the Administrator said the community room on Three Main and Three Main South has been locked for about three weeks due to it being too hot for the residents. She was not aware that the TV was broken in the community room on Three Main. Residents should have TV access when they do not have one in their room . The facility is expected to be more accommodating when access is denied to some of the rooms that the residents meet in. MO00238297 46888 49992

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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** 35394 40290 42795 46888 Based on observation, interview, and record review, the facility failed to ensure the first floor dining room was free from leaks (Resident #45), failed to ensure furniture and second floor common areas were clean and in good repair (Residents #86 and #106), failed to provide a homelike environment by serving meals with plastic utensils to residents on the second floor (Residents #106, #15, #50, and #126), failed to ensure the third floor shower room was clean and the toilet was in working order (Residents #87), failed to ensure Resident #120's bedroom wall was free from damage, failed to ensure the Air Conditioning (AC) units were free from dust and debris (Rooms 301, 303, 305, and 307), failed to ensure Resident #45 had a closet door. The sample was 30. The census was 151. Review of the facility's Maintenance Services policy, revised 10/24/22, showed: -Purpose: To protect the health and safety of residents, visitors, and facility staff; -Policy: The maintenance department maintains all areas of the building, grounds, and equipment; -Procedure: The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the Maintenance Department may include, but are not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines, maintaining the building free from hazards, ensuring adequate ventilation, establishing priorities in providing repair service, maintaining the paging system in good working order, providing routinely scheduled maintenance service to all areas, and other services that may become necessary or appropriate. Review of the facility's housekeeping job daily routine, undated, showed: -Job duties: Pull trash from rooms, check under beds for trash, sweep and mop under beds, wipe down windowsills, clean dressers, wipe down unmade beds, bed rails, sinks, pick up used linen from floor, and clean dining areas. Review of the facility's floor technician job daily routine, undated, showed: -Take out all trash, clean and mop utility rooms. Clean out shower rooms. Buff floors once weekly or when needed, sweep and mop hallways with machine. 1. Review of Resident #45's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/23/24, showed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively Intact. Observation on 7/9/24 at 11:43 A.M., showed the ceiling of the dining room leaking in two different areas. The water leaked from vents in the ceiling. Water was collecting into a bucket on the floor, with water on the floor around the bucket. Thirty-three residents were in the dining room at the time. During an interview on 7/9/24 at 11:43 A.M., Resident #45 said the roof leaks a lot in different areas. The dining room leak started last week and it does not feel homelike. Observation on 7/16/24 at 9:09 A.M., showed the ceiling of the dining room leaking in two different areas. The water leaked from vents in the ceiling. Water was collecting into a bucket on the floor, with water on the floor around the bucket. Review of a letter from a roofing company, showed on 07/15/24, they had been onsite to inspect the leak issues which had been an ongoing issue since 4/4/24 due to significant [NAME] damage. Review of the letter showed: -On site on 7/15/24 to look at leak issues with the current roof system . Existing roof system is poly-vinyl chloride (PVC). Upon inspecting the roof, we found it to have significant [NAME] damage in the field and wall flashings. Would advise the property owner to contact insurance company and set up a time for an adjuster and myself to do a thorough inspection. From the site visit, would recommend full roof replacement to ensure a water tight roof system . During an interview on 7/16/24 at 10:33 A.M., the Regional Director of Plant Operations said the dining room has leaked before and that the most current leaks started the past week. It is not homelike for residents to be eating while the ceiling is leaking. The facility has put in a drain line to try and help with the issue. 2. Review of Resident #106's quarterly MDS, dated [DATE], showed: -Cognitively intact. Observation of the second floor dayroom on 7/8/24 at 5:09 P.M. and 7/9/24 at 9:22 A.M., showed: -A loveseat missing one of its four legs, causing the loveseat to tilt backward; -A reclining chair with stained upholstery on the armrests and a rip in the seat, approximately ten inches long, leaving the stuffing exposed; -Brown circular stains on one ceiling tile and brown stained carpeting underneath the stained ceiling tile. A black baseboard, approximately three feet long, on top of the stained area of carpeting, exposing black spots along the bottom of the wall where the baseboard was missing; -Dark brown splatter marks of a dried substance along a section of wall, approximately four feet wide. Observation of the second floor dayroom on 7/11/24 at 8:37 A.M., showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A loveseat missing one of its four legs, causing the loveseat to tilt backward; -A reclining chair with stained upholstery on the armrests and a rip in the seat, approximately ten inches long, leaving the stuffing exposed; -Brown circular stains on one ceiling tile. A black baseboard, approximately three feet long, propped against the wall where it was missing on 7/8/24 and 7/9/24; -Dark brown splatter marks of a dried substance along a section of wall, approximately four feet wide. Observation of the second floor dayroom on 7/15/24 at 7:25 A.M., showed Resident #86 sat on the loveseat missing one of its four legs. The resident's positioning was leaned back due to the tilt of the loveseat. During an interview, Residents #86 and #106 said the furniture had been this way as long as they could remember and it was not nice to look at. Observation of the second floor dayroom on 7/16/24 at 7:11 A.M., showed a resident slept on the loveseat missing one of its four legs. Certified Nurse Aide (CNA) EE approached the resident and redirected him/her back to his/her room. During an interview, CNA EE said the residents should not have broken, torn, or ripped furniture. The residents deserve to have good furniture. During an interview on 7/15/24 at 7:39 A.M., Housekeeper KK said housekeeping staff cleans the dayroom at the end of the hall on a daily basis. The furniture in the dayroom is old. The couch is missing a leg and one of the chairs is torn. Management knows the furniture looks like this. During an interview on 7/16/24 at 8:32 A.M., Housekeeper JJ said housekeeping is responsible for cleaning the furniture in the dayroom every other day. They should wipe down the walls if there is splatter on them. He/She expected residents to have furniture in good condition. During an interview on 7/16/24 at 8:34 A.M., the Housekeeping/Laundry Director said housekeeping staff clean the dayrooms every day. They should also clean the furniture in the dayroom. If staff observe a piece of furniture is in need of repair, they should report the issue to Maintenance through TELS (technology-based building management system). If a furniture item is beyond cleaning or repair, the facility should get rid of it. During an interview on 7/16/24 at 10:31 A.M., the Maintenance Director said this morning, he was told about the second floor couch missing a leg. This is something he would expect staff to report to him. Staff can write a request for repairs, but the facility is trying to get away from written requests in case they get lost. All desktop computers have TELS software, which is the system used by staff to make repair requests. 3. Review of Resident #15's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Supervision or touching assistance required for eating; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included stroke, dementia, hemiparesis (weakness on one side of the body) or hemiplegia (paralysis on one side of the body), and malnutrition. Review of Resident #50's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Supervision or touching assistance required for eating; -Diagnoses included malnutrition. Review of Resident #126's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Supervision or touching assistance required for eating; -Diagnoses included malnutrition. Observation of the second floor dining room on 7/9/24 at 12:09 P.M., showed 21 residents seated throughout the dining room, eating lunch. Lunch consisted of a slice of meatloaf, mashed potatoes, and mixed vegetables. All residents had plastic spoons to eat their meals; no regular utensils. Several residents dropped food as they attempted to use their plastic spoons to scoop meatloaf. During an interview, Resident #106 said it isn't easy to eat meat with a spoon and he/she thought it was a challenge. It would be nice to have a fork. Observation of the second floor dining room on 7/12/24 at 11:43 A.M., showed 25 residents seated throughout the dining room, eating lunch. Lunch consisted of a breaded fish patty, spaghetti, and sliced carrots. All meals were served with a plastic fork and a plastic spoon; no regular utensils. During an interview, Resident #15 said he/she could not cut the fish patty with the plastic fork, so he/she ate with his/her hands. Resident #50 said he/she could not cut the fish patty with the plastic utensils. He/She had to pick up the patty to eat it. Observation of the second floor dining room on 7/15/24 at 7:42 A.M., showed 22 residents seated throughout the dining room, eating breakfast. Breakfast consisted of a sausage patty, scrambled eggs, biscuit, and hot cereal. All residents had plastic spoons to eat their meals; no regular utensils. During an interview, Resident #126 said he/she just has to make due with using a plastic spoon to cut his/her sausage patty. Observation of the second floor dining room on 7/16/24 at 7:35 A.M., showed 13 residents seated throughout the dining room, waiting for breakfast. All tables were set with one plastic spoon and a napkin. During an interview on 7/15/24 at 2:48 P.M., CNA R said the second floor is a memory care unit. Residents were served meals with plastic utensils because they try to keep the regular utensils. This has been going on for a couple of years. The residents are given plastic spoons a lot, more than forks. It would be easier for residents to cut up their food with regular, solid utensils instead of plastic utensils. He/She would prefer to have regular utensils with his/her meals. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/24 at 8:44 A.M., Licensed Practical Nurse (LPN) D said residents on the second floor have been served meals with plastic utensils. Yesterday, residents were served egg rolls and noodles with plastic spoons, no forks. It didn't make sense. He/She has been asking dietary about why this is happening for the longest time and doesn't get an answer. During an interview on 7/16/24 at 12:14 P.M., the Dietary Manager said meals on the second floor were served with plastic utensils because the regular silverware was not coming back to the kitchen. It is a safety issue. If a resident wants regular silverware, dietary can get that for them. Nursing staff tell him not to send real silverware to the second floor. The facility has enough silverware to provide at each meal to all residents in the facility. They ran out of regular spoons, but they came in today. If plastic utensils are going to be used on the second floor, residents should receive forks as well as spoons. It would be helpful to eat certain food items, such as noodles, with a fork. It is not considered homelike to serve meals with plastic utensils. During an interview on 7/16/24 at 11:17 A.M., the Administrator said it was recently brought to her attention that residents on the second floor were being served meals with plastic utensils. This issue has been going on for a couple of weeks. The issue has been partly due to shortage of supply and partly due to needed education. She would expect all residents to receive all meals with regular utensils. 4. Review of the Resident #87's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Uses a manual wheelchair; -Independent with toilet transfers. Observations on 7/8/24 at 8:36 A.M. and 7/9/24 at 12:15 P.M., showed the Third floor Main tub room with the door unlocked and partially open. The tub room had a bathroom stall with a door that was unlocked and opened. The toilet had large amounts of toilet paper and fecal material in the bowl that had clogged the toilet. Flies were landing on the toilet paper and fecal material in the toilet bowl. Observations and interview on 7/10/24 at 8:31 A.M., showed Resident #87 self-propelled him/herself in his/her wheelchair into the Third floor Main tub room and into the bathroom stall. The door was left open by the resident. The resident stood up and urinated into the toilet bowl that was clogged with toilet paper and fecal material. When the resident propelled him/herself out of the tub room, he/said the toilet was sick. During an interview on 7/9/24 at 12:10 P.M., Certified Medication Technician (CMT) AA said the clogged toilet on Third floor Main tub room has been like that for about a month and thought either housekeeping or maintenance were supposed to fix the issue. He/she did not report the issue because he/she thought someone in the facility administration was already aware. During an interview on 7/10/24 at 8:21 A.M., Housekeeper Z said the clogged toilet on Third floor Main tub room had been like that for about two weeks and was sure maintenance was aware of the issue. He/she had not reported the clogged toilet to anyone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at approximately 10:00 A.M., the Maintenance Director said he was not aware of the Third floor tub room until 7/10/24. A clogged community toilet is something he would encourage staff to report right away. A clogged toilet is not a homelike environment. During an interview on 7/16/24 at 11:16 A.M., the Administrator said she would expect the staff to report a clogged toilet immediately to the Maintenance Director or the Administrator. A clogged toilet is not homelike. 5. Review of Resident #120's, annual MDS, dated [DATE], showed: -Cognitively intact. Observation and interview on 7/9/24 at 12:00 P.M., 7/12/24 at 3:31 P.M. and 7/16/24 at 8:10 A.M., showed in the resident's room behind his/her bed, the baseboards were halfway off exposing crumbling drywall and clusters of dark circular spots on the intact drywall. The resident said he/she was visually impaired and cannot see the wall. During an interview on 7/16/24 at 8:18 A.M., CNA O said he/she thought the resident's walls were like that for one to two weeks. Staff normally let maintenance department know about repairs. He/She did not report the damaged walls to anyone. During an interview on 7/16/24 at 8:30 A.M., Housekeeper P said he/she cleans rooms on third floor but did not know how long the resident's walls were damaged. He/She would normally report any issues he/she finds to his/her manager. He/She did not report the resident's damaged wall to anyone. During an interview on 7/16/24 at 10:24 A.M., the Maintenance Director said he was only made aware of the resident's wall on 7/15/24. The staff can place a request for repairs in the computer or if they do not have computer access, then staff are expected to inform their supervisor and that person can add the repair request. Damaged walls were not a homelike environment. During an interview on 7/16/24 at 11:16 A.M., the Administrator said she expected staff to place a request for repairs in the computer or inform their charge nurse or supervisor of damaged walls in a resident's room. Damaged walls were not a homelike environment. 6. Observation of room [ROOM NUMBER] during the survey, showed: -On 7/8/24 at 9:10 A.M., the AC unit by the window had dust and debris build up on the outside and inside of the vent; -On 7/10/24 at 6:53 A.M., the AC unit by the window had dust and debris build up on the outside and inside of the vent; -On 7/11/24 at 7:09 A.M., the AC unit by the window had dust and debris build up on the outside and inside of the vent. Observation of room [ROOM NUMBER] during the survey, showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/8/24 at 12:20 P.M., the bathroom had a burned out light bulb. The AC by the window had dust and debris build up on the outside and inside of the vent; -On 7/10/24 at 7:01 A.M., the bathroom had a burned out light bulb. The AC by the window had dust and debris build up on the outside and inside of the vent; -On 7/11/24 at 7:10 A.M., the bathroom had a burned out light bulb. The AC by the window had dust and debris build up on the outside and inside of the vent. Observation of room [ROOM NUMBER] during the survey, showed: - On 7/8/24 at 9:10 A.M., the floors were sticky with a liquid spill and have various locations of trash and debris. The AC by the window had dust and debris build up on the outside and inside of the vent; -On 7/10/24 at 6:56 A.M., the floors were sticky with a clear liquid spill. The AC unit by the window had dust and debris build up on the outside and inside of the vent; -On 7/11/24 at 8:00 A.M., the floors were sticky with a clear liquid spill. The AC unit by the window had dust and debris build up on the outside and inside of the vent. Observation of room [ROOM NUMBER] during the survey, showed: -On 7/9/24 at 8:56 A.M., the bathroom had a burned out light bulb. The AC by the window had dust and debris build up on the outside and inside of the vent; -On 7/10/24 at 6:59 A.M., the bathroom had a burned out light bulb. The AC by the window had dust and debris build up on the outside and inside of the vent; -On 7/11/24 at 7:13 A.M., the bathroom had a burned out light bulb. The AC by the window had dust and debris build up on the outside and inside of the vent. During an interview on 7/16/24 at 7:10 A.M., Housekeeper P said housekeepers were expected to clean residents' floors once a day and as needed. The AC unit should be cleaned by maintenance staff. During an interview on 7/16/24 at 10:27 A.M., the Regional Director of Plant Operations said housekeepers were expected to dust the outside of the AC units and the inside was cleaned every three weeks by maintenance staff. He expected AC units to be clean and free from debris and dust build up. He expected all staff to inform maintenance staff if a resident's bathroom light was burned out. He expected for residents rooms to be clean. 7. Review of Resident #45's quarterly MDS, dated [DATE] showed the following: -Cognitively Intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 7/8/24 at 12:20 P.M., showed the resident's closet door was missing. A curtain lay on top of boxes on the floor of the closet. The resident said he/she really wants a closet door due to his/her closet being located right next to the door to the hallway. Other residents come and mess with his/her things. The resident placed a curtain over his/her belongings. Observation on 7/10/24 at 7:01 A.M., showed the resident's closet door was missing. A curtain lay on top of boxes on the floor of the closet. During an interview on 7/16/24 at 10:29 A.M., the Regional Director of Plant Operations said he was not aware that the resident did not have a closet door. He said it is not homelike to have a missing closet door. MO00238490 MO00230468 MO00232891 MO00234203 MO00235027 MO00236928 MO00237491 MO00237997

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40290 Based on interview and record review, the facility failed to perform criminal background checks (CBC) on newly hired employees prior to the employee's start date, in accordance with the facility's policy, for three of 10 employees hired since the last survey. The census was 151. Review of the facility's Staff Screening policy, revised 10/24/22, showed: -Purpose: To ensure the highest quality of care through the utilization of qualified staff, consultants and volunteers; -Policy: The Facility will utilize reasonable and prudent criminal background screening and reference checks for prospective staff, contractors/consultants, registry/temporary staff, and volunteers; -Procedure: Prior to employment or commencement of a contract, the facility will verify and document or obtain a copy, if applicable, of the following information that may include, but not limited to criminal background checks. 1. Review of Certified Nurse Aide (CNA) AAA's employee file, provided for review on 7/10/24, showed: -Hire date 11/1/23; -No CBC requested or received; -Family Care Safety Registry (FCSR) check run on 7/10/24. 2. Review of Dietary Aide (DA) BBB's employee file, provided for review on 7/10/24, showed: -Hire date 2/17/23; -No CBC requested or received; -FCSR check run on 7/10/24. 3. Review of Maintenance Assistant CCC's employee file, provided for review on 7/10/24, showed: -Hire date 3/7/24; -No CBC requested or received; -FCSR check run on 7/10/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 7/15/24 at 10:09 A.M., Human Resources (HR) said when someone applies for a position at the facility, she is responsible for running pre-employment background checks, which includes running a CBC or FCSR. The pre-employment background checks have to be run on a new hire before the employee starts working in the facility. Pre-employment background checks should be retained in the employee files. Sometimes things get hectic and she runs the background checks as she goes and saves them. She did not see the missing background checks when she pulled the employee files for review. 5. During an interview on 7/16/24 at 11:17 A.M., the Administrator said she expects HR to run the appropriate background checks on all new hires prior to the employee starting work in the facility. Pre-employment background checks should be retained in the employee files.

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	265585	A. Building B. Wing	07/16/2024

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

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview, and record review, the facility failed to update records of residents' personal possessions per facility policy for two sampled residents (Resident #42 and #39). Resident #42 purchased dresses and socks that were not documented on the resident's inventory sheet and were missing after being sent to laundry. Resident #39 purchased shirts and pants that were not documented on the resident's inventory sheet and were missing after being sent to laundry. The sample was 30. The census was 151. Review of the facility's admission policy, revised July 2022, showed: -Laundry services: The facility will clean the resident's laundry (in commercial machines with industrial detergent) at no additional charge to the Resident. The family will pick up and clean the resident's laundry and the family will provide a covered, plastic laundry container to the facility; -Family will ensure that the resident's clothing has been pre-marked with his or her name and is periodically remarked as needed. In addition, the resident understands that the facility does not assume responsibility for lost or damaged laundry except as required by state law. Review of the facility's Lost and Prevention Policy, dated 10/24/22, showed: -Policy: The facility is committed to preventing the misappropriation of resident property. The facility will exercise reasonable care for the protection of the resident's property from theft or loss; -The facility investigates all reports of stolen items, makes reports to authorities as required by law, and maintains documentation of all reports of lost or stolen property; -Upon admission, facility staff provides the resident and/or his/her representative with the facility's policy regarding theft prevention and the relevant sections of the state law relating to theft and loss; -Inquiries regarding lost or stolen items are reported to the Administrator or Social Service Director; -Measures to Secure Personal Property: Upon admission and upon request thereafter, the facility provides the resident and/or his/her representative with a copy of the resident inventory; -Items brought into the facility after admission are added to the resident inventory at the request of the resident or his/her representative; -The resident or his/her representative should notify the Administrator of any items removed from the facility that need to be deleted from the resident inventory; (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility is not liable for those items which the resident or representative has not requested be added to the resident inventory or for items that have been deleted from the resident inventory; -It is at the discretion of the resident or their representative to indicate items that are not subject to addition or deletion from the Resident Inventory due to frequent removal from the facility (clothing, books, etc.); -Items brought to the facility are marked, to the extent possible, identifying the owner of the item (engraving, tagging, marking clothing tags, etc.); -The Administrator or designee investigates all reports of stolen items and documents the investigation Theft/Loss Report. The investigation may consist of the following: -An interview with the facility staff member notifying the Administrator of the missing item(s); -An interview with any witnesses that may have knowledge of the missing items; -An interview with the resident (if medically appropriate); -An interview with the person (if any) accused of taking the resident's property; -A review of the resident Inventory record to determine if the missing items were recorded; -Interviews with facility staff (on all shifts) having contact with the resident during the past 48 hours; -Interviews with the resident's roommate, family members, and visitors; -A search of the laundry room for missing articles of clothing. 1. Review of the Resident #42's medical record, showed he/she was admitted on [DATE]. Review of the resident's care plan, in use during survey, showed: -Focus: Resident wishes to stay long term care; -Goal: Will continue to express satisfaction with living arrangements; -Interventions: Encourage social interactions and participation in activities with other residents; Evaluate discharge and long term care goals quarterly and as needed. Review of the resident's personal inventory sheet, dated 2/21/24, showed: -Seven T-shirts (purple, gray, powder blue, red, two white, and yellow); -Three pairs of shorts (two navy blue and black); (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One pair of shoes; -One pair of pink stockings; -One Samsung cell phone and three chargers; -One Continuous positive airway pressure (C-PAP, a machine helps treat sleep apnea) machine; -One electric wheelchair. Observation and interview on 7/15/24 at 8:18 A.M., showed the resident in bed and said he/she had clothing at one point. He/She had approximately seven or eight dresses. Four dresses have not been returned from laundry, but the name tags could have fallen off. The resident's closet contained five pairs of pants, four jackets, two sweaters, three shirts, and three dresses. During observation and interview on 7/15/24 at 10:49 A.M., the resident said he/she told the Minimum Data Set (MDS) Coordinator and the person in laundry about the dresses but had heard nothing. There was an inventory sheet filled out. During an interview on 7/15/24 at 10:50 A.M., Licensed Practical Nurse (LPN) S said there were a lot of changes with laundry. Anyone that could do laundry was doing it. Most of the laundry staff were let go. During an interview on 7/15/24 at 11:24 A.M., Central Supply GGG said he/she found three of four of the resident's dresses. He/She returned them to the resident at that time. During an interview 7/15/24 at 11:55 A.M., the resident said Central Supply GGG returned some dresses, and they were currently hanging in his/her closet, but there were four other dresses that were lost. Central supply GGG said he/she would keep his/her eye open for them. The dresses were a solid blue dress, a blue print dress, a purple and black dress, and a black and beige dress. The resident also had missing socks. The resident showed a pair of Bombas socks (designer socks with seamless toes and grippy bottoms and innovative features like blister tabs and arch support) from his/her drawer with his/her name inside the sock. The dresses were purchased by his/her friend. They were expensive. They came from a specialty company that has dresses that open in the back for people who are incontinent. When he/she has new clothing, he/she informs the social worker and the social worker updates the inventory sheet. 2. Review of Resident #39's medical record, showed he/she was admitted on [DATE] and readmitted on [DATE]. Review of the resident's care plan, in use during survey, showed: -Focus: Resident wishes to stay long term care; -Goal: Will continue to express satisfaction with living arrangements; -Interventions: Encourage social interactions and participation in activities with other residents; Evaluate discharge and long term care goals quarterly and as needed. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's personal inventory sheet, dated 3/6/23, showed: -Six button down shirts; -Five T-shirts; -Five pairs of jeans -12 pairs of boxers; -10 pairs of socks; -Two pairs of shoes; -One pair of slippers; -One Jacket; -One coat. Review of the resident's personal inventory sheet, dated 4/3/23, showed: -Six button down shirts; -Five T-shirts; -Five pairs of jeans -12 pairs of boxers; -10 pairs of socks; -Two pairs of shoes; -One Jacket; -One coat; -One television. Observation and interview 7/12/24 at 4:03 P.M., showed he/she wore a long sleeve, gray plaid shirt and jeans and said he/she bought some clothes, but they were either ruined or lost when it got to laundry. It did not come back. He/She was embarrassed to let the surveyor look into his/her closet because he/she did not have much clothing. His/Her clothes do not go to laundry anymore. He/She washes his/her clothes by hand and hangs them up in his/her room. The resident had four long-sleeved, button-down shirts, two short sleeved shirts, and one pair of jeans. The resident said he/she had approximately 12 pairs of jeans and 12 shirts. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/16/24 at 8:45 A.M., the resident was observed wearing a long sleeve, gray plaid shirt and jeans. He/She said he/she reported his/her missing clothes to staff at the time. It went to laundry and did not come back. There are so many new people in laundry and the resident said he/she was not the only one with missing clothing. 3. During observation and interview on 7/15/24 at 11:13 A.M., Laundry Aide EEE and Laundry Aide FFF said they worked for the facility for approximately one month. When they started, there was a lot of lost clothing. They had to reorganize everything. There are clothes on a rack on the back wall. Observation showed a long rack against the back wall with clothing. Laundry Aide EEE and Laundry Aide FFF said the clothing on the rack was mostly new clothing without names. If a resident lost clothing, they will look through the rack and see if there is something that matched the description and take it to the resident to identify it. Laundry Aide FFF and staff from Central supply found Resident #42's dresses. He/She found three of the resident's dresses. Laundry Aide EEE and Laundry Aide FFF did not know anything regarding Resident #39's clothing. Some challenges they face are nursing does not inform laundry if a resident moved rooms or if there was a new resident, so they had to keep following up to where the residents are. The Certified Nurse Aides (CNAs), nurses, and social workers come down to laundry and take clothing and they do not inform laundry staff. Nursing also does not separate the clothing. They may clean up a resident or give a bed bath, put everything together such as the resident's personal clothing, soiled brief, linen, wash cloths, and towels in a bag. There are separate bins for soiled linen. Laundry staff remove the bag from upstairs and do the laundry. As a result, they did not know residents' clothing was in the bag, so they have bleached residents' clothing and washed soiled briefs. They report it to management. 4. During an interview on 7/15/24 at 12:32 P.M., Social Worker said the social worker designee updates the inventory sheets. When there is a new admit, the designee completes the inventory sheet. The residents are encouraged to call Social Worker and Central Supply GGG if they are updating the inventory sheet. The Social Worker was unaware of the resident's missing clothing, but the resident knows to update the list. 5. During an interview on 7/16/24 at 11:18 A.M., the Administrator said residents are to report missing or lost clothing to social services and they report it to laundry. Any staff member can report it to laundry. The Administrator was aware of Resident #42's missing clothing, but not Resident #39's missing clothing. She would expect the inventory to be completed and updated. If there are missing clothing, they try to identify who the clothing belongs to. MO00238297 MO00238490 MO00234580 MO00237491 MO00235408

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49992 Based on observation, interview and record review, the facility failed to address behaviors related to pulling the call light out of the wall, on the care plan for one sampled resident (Resident #96). The sample was 30. The census was 151. Review of Resident #96's medical record, showed his/her diagnoses included Alzheimer's disease, muscle weakness, insomnia, depression, low blood pressure, high cholesterol, anxiety disorder and difficulty in walking. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/30/24, showed: -Severe cognitive impairment; -Required supervision or touching assistance from staff with eating, oral hygiene, upper body dressing, putting on or taking off footwear and personal hygiene; -Required partial to moderate assistance from staff with toileting, showering, lower body dressing; -Independent for locomotion. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has an Activities of Daily Living (ADLs) deficit; -Goal: The resident will maintain current level of function in ADLs; -Interventions: The resident needs limited assistance with his/her dressing, bathing, personal hygiene, grooming, toileting, transfers, and bed mobility; -Focus: The resident has a behavior problem by declining personal care, medications and yelling; -Goal: The resident will have no evidence of behavior problems; -Interventions: Redirect him/her with one to one conversation with staff to assess his/her needs and reasoning for being upset, anticipate and meet the resident's needs, encourage resident to express feelings appropriately, explain all procedures to resident before starting and allow the resident to adjust to the changes, and report to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) of declining care and/or medications to be reported to the Primary Care Physician (PCP) and responsible party (RP); -The care plan did not reflect the resident's behavior related to pulling out the call light. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record, showed there no documentation in the nurses notes and social service notes of the resident pulling out the call light. Observation on 7/8/24 at 9:27 A.M., 11:01 A.M., and 4:59 P.M., showed the notification light above the resident's door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. Observation on 7/9/24 at 7:54 A.M., 9:53 A.M., and 10:56 A.M., showed the notification light above the door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. Observation on 7/10/24 at 8:05 A.M. and 1:21 P.M., showed the notification light above the door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. Observation on 7/11/24 at 7:20 A.M., 9:07 A.M., and 11:45 A.M., showed the notification light above the door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. Observation on 7/12/24 at 9:41 A.M., showed the notification light above the door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. During an interview on 7/12/24 4:37 P.M., Licensed Practical Nurse (LPN) D said the call light was removed due to the resident's behaviors, and sometimes he/she will remove the plug that is put into the call light port. Observation on 7/12/24 at 5:14 P.M., showed the notification light above the door was lit, the call light was not plugged into the wall, and the call light box at the nurse's station was lit, but there was no audible sound. During an interview on 7/15/24 at 11:09 A.M., LPN WW said residents use the call lights to ask for help. Observation on 7/15/24 at 11:15 A.M., showed the notification light above the door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. During an interview on 7/15/24 at 11:18 A.M., Certified Nursing Assistant (CNA) E said the call light notifies staff that a resident needs assistance, a resident may have fallen, or is sick. The residents have bells they can use to notify staff, but CNA E does not know where the bells are stored. The resident has a history of pulling out the call light. During an interview on 7/15/24 at 11:28 A.M., the Regional Director of Plant Operations (RDPO) and the Director of Maintenance (DM) said they were not aware the call light had been removed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/15/24 at 2:40 P.M., showed the notification light above the door was lit, the call light was not plugged into wall, and the call light box at the nurse's station was lit, but there was no audible sound. During an interview on 7/15/24 at 3:03 P.M., the RDPO said the call light was replaced. He was informed the resident would pull the call light out. During an interview on 7/16/24 at 12:30 P.M., the Director of Nursing (DON) and Administrator said they expected each resident to have a functioning call light in their room and were unaware the call light was pulled from the wall in the resident room. Bells would be an alternative device used to notify staff until the call light was repaired or replaced. They expected the nurses to document any resident behaviors related to call lights and the behaviors would be in the care plan.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to document a resident's involvement in discharge planning for one resident (Resident #299), who was transferred to another facility. The census was 151. Review of the facility's Transfer and Discharge Planning policy showed: -Purpose: To ensure that adequate preparation and assistance is provided to residents prior to transfer or discharge from the facility; -Policy: Social Services staff will conduct a Discharge Planning Assessment and will help orient the resident to the impending discharge. -Procedure: -Social Services staff will document the discharge planning, preparation, and the resident's post-discharge needs in a Discharge Planning Assessment, or similar form in the electronic health record; -The Discharge Planning Assessment will be filed in the resident's medical record. Review of Resident #299's medical record, showed: -admitted [DATE]; -Resident is his/her own responsible party; -Diagnoses included stroke, atrial fibrillation (irregular heartbeat), acquired absence of left leg below knee, acquired absence of right leg below knee, and need for assistance with personal care; -On 5/10/24 at 1:35 P.M., the Social Services Director (SSD) documented the resident transferred to other facility today. Transported with all personal belongings and medications per physician; -No documentation related to whether the transfer was initiated by the facility or resident, no documentation of the resident's involvement in the decision to transfer him/her to another facility, and no Discharge Planning Assessment. During an interview on 7/15/24 at 12:32 P.M., the SSD said the resident was not happy at the facility and requested a transfer. He/She was transferred to another nursing facility in a different state. The discharge planning involved the resident and the SSD. The SSD did not document any of her conversations with the resident about his/her request to transfer to another facility. There should be documentation in the resident's medical record about the resident's involvement in discharge planning. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 11:17 A.M., the Administrator said the resident transferred to a facility in another state because he/she wanted to be closer to his/her previous home. She expected staff to have documented in the resident's medical record that the transfer was the resident's choice. She expected the resident's medical record to include documentation of the resident's involvement in discharge planning. MO00235408

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on interview and record review, the facility failed to ensure a discharge summary was completed for one resident, including a recapitulation of the resident's stay and a final summary of the resident's status at the time of discharge (Resident #299). The census was 151. Review of the facility's Transfer and Discharge Planning policy showed: -Purpose: To ensure that adequate preparation and assistance is provided to residents prior to transfer or discharge from the facility; -Policy: Social Services staff will participate in assisting the resident with transfers and discharges and preparing the Discharge Summary and Discharge Care Plan as part of the interdisciplinary team (IDT); -Social Services staff will assist in developing the Discharge Summary and Discharge Care Plan that is developed with the IDT; -Members of the IDT may use Discharge Planning Questionnaire, or similar form in the electronic health record, to gather information to complete the Discharge Summary and Discharge Care Plan for the resident. The IDT team should ask the resident, resident's family members, attending physician, nursing staff, Social Services staff, and any other individuals who may be able to provide answers to the questions; -A copy of the Discharge Summary will be provided to the resident and/or the resident's family member or caretaker upon discharge when return is not anticipated. The discharge summary will include the following information: -Recapitulation of the resident's stay including, but not limited to, diagnoses, course of illness, treatment, and pertinent lab, radiology, and other consultation results; -Summary of the resident's status based on the most recent comprehensive assessment; -A copy of the Discharge Summary and Discharge Care Plan will be maintained in the resident's medical record. Review of Resident #299's medical record, showed: -admitted [DATE]; -Resident is his/her own responsible party; -Diagnoses included stroke, atrial fibrillation (irregular heartbeat), acquired absence of left leg below knee, acquired absence of right leg below knee, and need for assistance with personal care; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/10/24 at 11:01 A.M., the Minimum Data Set (MDS) nurse documented order received to discharge to other facility with medications; -On 5/10/24 at 1:35 P.M., the Social Services Director (SSD) documented the resident transferred to other facility today. Transported with all personal belongings and medications per physician; -No documentation related to why the transfer occurred and if the resident was involved in the discharge planning, no recapitulation of the resident's stay, and no comprehensive final discharge summary of the resident's status at the time of discharge. During an interview on 7/15/24 at 12:32 P.M., the SSD said the resident was not happy at the facility and requested a transfer. He/She transferred to another nursing facility in a different state. She did not document any of her conversations with the resident about his/her request to transfer to another facility. She did not document a discharge summary. This information should be documented in the resident's medical record. During an interview on 7/16/24 at 10:20 A.M., the MDS nurse said on 5/10/24, she was notified the resident was accepted to another facility and a physician order for discharge was needed. She called the physician and got the order, then added a note to the resident's medical record. She was not the discharging nurse. On the day of transfer or discharge, the discharging nurse should perform a full assessment of the resident, including obtaining a full set of vital signs. A discharge summary should be completed by the discharging nurse, SSD, or both, and a copy of the discharge summary should be given to the resident, along with their list of medications and inventory sheet. The discharge summary should be signed by the resident and retained in the resident's medical record. During an interview on 7/16/24 at 11:17 A.M., the Administrator said the resident transferred to a facility in another state because he/she wanted to be closer to his/her previous home. On the day of a resident's transfer or discharge, the SSD is responsible for providing the resident with a discharge summary. The discharge summary should be signed by the resident and retained in the resident's medical record. The resident's medical record should show the resident signed off on receiving his/her personal belongings and the appropriate discharge paperwork. MO00235408

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 35394 Based on observation, interview and record review, the facility failed to ensure five residents who required assistance with activities of daily living (ADL) received personal care, nail care, and facial hair hygiene in accordance with their needs and preferences (Residents #37, #22, #88, #51, and #124). The sample was 30. The census was 151. Review of the facility's Care and Services policy, dated 10/24/22, showed: -Policy: Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth; -Procedure: The Facility will have sufficient staff to provides services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being as determined by individualized resident assessments and plans of care; -The identification of needed care and services begins during the pre-admission process; -Once admitted , the resident receives an admission assessment where initial care and service needs are identified; -A resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty will receive appropriate treatment in accordance with assessed behavioral health needs; -A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty should not display a pattern or decreased social interaction and/or increased withdrawn, angry or depressive behaviors unless the resident's clinical condition demonstrates that development of such pattern was unavoidable; -The Interdisciplinary Team (IDT) receives and reviews initial assessment information to ensure that members of the IDT interact with residents in a manner that enhances self-esteem and self-worth, such as activities related to bathing, grooming, dining, recreational and social opportunities; -The IDT facilitates opportunities for residents to exercise choice and self-determination during ADLs; -The IDT provides care and services to residents with reasonable accommodations of each resident's individual needs and preferences; -The licensed nurse or designee documents and notifies the resident's physician and responsible party of: -Change in condition, including progress and/or decline in physical or mental function; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident refusal of care or services; -Unusual circumstances. 1. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/10/24, showed: -Severe cognitive impairment; -Rejection of care behavior not exhibited; -Partial/moderate assistance for showering/bathing; -Diagnoses included Alzheimer's disease, anxiety, depression, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), need for assistance with personal care, generalized muscle weakness, unsteadiness on feet, lack of coordination, and other sites of candidiasis (fungal infection caused by an overgrowth of yeast). Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has an ADL self-care performance deficit related to dementia, limited range of motion, and pain; -Interventions: Resident needs assistance of set up of his/her clothing, toileting, transfers, meals, and snacks; -Focus: Resident is resistant of care related to Alzheimer's disease and mood; -Interventions: Encourage as much participation/interaction by the resident as possible during care activities. Give clear explanation of all care activities prior to and as they occur during each contact. If possible, negotiate a time for ADLs so that resident participates in the decision-making process and return at the agreed upon time; -The care plan failed to identify the resident's individual needs and preferences related to showering/bathing, including need for partial to moderate assistance from staff for showering/bathing. Review of the resident's electronic physician order sheet (ePOS), showed an order, dated 6/10/24, for Nystatin (antifungal medication) powder 10000 unit/gram, applied to groin, under breast topically every day and evening shift for fungal rash. Review of the facility's shower schedule, undated, showed the resident scheduled for showers on Monday and Thursday evening shift. All showers must be documented. Report all refusals to the charge nurse. Review of the resident's shower sheets for June and July 2024, showed: -On 6/10/24, Certified Nurse Aide (CNA) documented shower completed. Nystatin used under breast and between folds; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 6/14/24, CNA documented shower completed. Nystatin under all folds; -On 6/26/24, CNA documented shower completed. Nystatin applied under breast, stomach; -On 7/9/24, CNA documented shower completed; -The resident missed approximately seven showers. Observation on 7/8/24 at 10:08 A.M., showed the resident sat in a chair in his/her room. A sour, pungent odor permeated from the resident and his/her bed. During an interview, the resident exhibited confusion. He/She said he/she takes showers and responded to further questions in a nonsensical manner. Observation on 7/9/24 at 8:33 A.M., showed CNA E assisted the resident in getting undressed for a skin assessment. A strong odor permeated from the resident. Powder noted underneath the resident's breasts. During an interview, the resident said he/she only showers when he/she has to go somewhere, otherwise, he/she may only take a shower once or twice a week. During an interview on 7/9/24 at 8:45 A.M., CNA E said the resident has a strong odor coming from his/her stomach and breast folds. He/She had the odor yesterday and this morning. The resident has yeast under his/her folds and needs a medicated powder and showers. This morning, CNA asked the resident if CNA could assist him/her in having a shower and the resident said he/she already had one, but he/she had not. CNA asked again and the resident agreed to the shower, which was provided this morning. The resident will usually agree to taking a shower if staff come back and ask again later, or if they offer the resident a soda. The resident does not usually refuse showers altogether. Observation on 7/11/24 at 8:50 A.M., showed Certified Medication Technician (CMT) F opened the door to the resident's room and a sour, pungent odor emitted from the room. The resident seated in a chair next to his/her bed. During an interview, CMT F said he/she smelled a strong odor and did not know where it was coming from. Observation on 7/12/24 at 11:55 A.M., showed the resident sat in a chair in his/her room. He/She wore the same outfit as the day before. A pungent, sour odor permeated from the resident. During an interview on 7/15/24 at 2:48 P.M., CNA R said the resident cannot reach everything on his/her body and requires assistance of two staff for showers. The resident has an odor to him/her. If staff give him/her a snack or soda, the resident will take a shower. Showers are provided twice a week and as needed. There is a shower schedule posted at the nurse's station for staff to follow. Showers are scheduled for day and evening shift. The facility is short-staffed at times. When staffing is short, showers do not get done. During an interview on 7/9/24 at 8:55 A.M., Licensed Practical Nurse (LPN) D said the resident is behavioral, but easy to redirect. He/She likes snacks and snacks will usually help staff to get him/her to do things, like agreeing to take showers. Showers should be provided per the shower schedule and as needed. CNAs document showers on a shower sheet and then give the completed shower sheet to the nurse. If a resident refuses their shower, the CNA should notify the nurse. The nurse will adjust the shower schedule as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #22's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included aphasia (language disorder), cerebral palsy (congenital disorder of movement, muscle tone, or posture), dementia, quadriplegia (paralysis of all four limbs), and seizure disorder; -Impairment on both sides of the upper and lower extremities; -Has a feeding tube; -Requires substantial/maximal assistance for personal hygiene and showers/bath. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has an ADL self-care performance deficit related to cerebral palsy; -Goal: Resident will maintain current level of function; -Interventions: -Bed mobility: Resident is totally dependent on 1-2 staff for repositioning and turning in bed during routine rounds and as necessary; -Toilet use: Resident is not toileted; -Transfer: Resident is totally dependent on 2 with mechanical lift, staff for transferring; -Focus: Resident has contractures (loss of range of motion caused by muscle and tendon shortening), he/she requires total care with mobility from staff. Resident is unable to use call light related to contracture and cognition; -Goal: Will be free of thrombus formation (the formation of a blood clot within arterial or venous blood vessels, limiting the natural flow of blood), skin-breakdown, and fall related injury; -Interventions: -Bolster wrap (provides elevated edges on the bed) to the mattress for positioning while in bed; -Daily bilateral upper extremity (BUE) splinting of resting hands, begin with 1 hour daily monitor skin integrity clean palm with soap and water daily keep nails trimmed; -Geri-chair (medical reclining chair) use for positioning while out of bed. Review of the resident's ePOS, dated July 2024, showed an order dated 1/15/19, for Ketoconazole (antifungal) Shampoo 2%. Apply to scalp topically every day shift every Tuesday, Thursday, and Saturday for dandruff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's electronic Medication Administration Record (eMAR), dated July 2024, showed Ketoconazole Shampoo 2%. Apply to scalp topically every day shift every Tuesday, Thursday, and Saturday; -On 7/4/24: blank; -On 7/6/24: staff documented see progress notes. Review of the resident's progress notes, showed on 7/6/24 at 12:55 P.M., Ketoconazole Shampoo 2%. Apply to scalp topically every day shift every Tuesday, Thursday, and Saturday. Resident resting in bed. Observation of the resident, showed: -On 7/8/24 at 10:44 A.M., the resident in bed, eyes closed. He/She had a dried whitish colored substance on his/her beard; -On 7/10/24 at 7:41 A.M., the resident in bed. The resident's nails were long. The resident had a full beard. His/Her hair had white flakes throughout the hair; -On 7/15/24 at 11:00 A.M. and 3:00 P.M., the resident's nails were long with buildup of dirt underneath the nail bed. His/Her hair had white flakes throughout the hair; -On 7/16/24 at 8:25 A.M., the resident's nails were long with buildup of dirt underneath the nail bed. His/Her hair had white flakes throughout the hair. Review of the resident's shower sheets, showed no shower sheets had been provided to surveyor for July 2024. 3. Review of Resident 88's quarterly MDS, dated [DATE], showed: -Mild cognitive impairment; -Diagnoses included high blood pressure, renal (kidney) failure, hyperlipidemia (high level of lipids in the blood), hemiplegia (partial paralysis on one side), malnutrition, anxiety, depression, and psychotic disorder; -Range of motion impairment to one side of the upper extremity; -Requires substantial/maximal assistance with personal hygiene and showers/bath. Review of the resident's care in plan, in use during survey, showed: -Focus: Resident has an ADL self-care performance deficit related to impaired balance, limited mobility. Resident prefers to wear adult briefs at all times; -Goal: No decline in ADL functioning; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: -Encourage out of bed daily; -Incontinent care as needed; -Skin assessment as needed; -Resident is total assist of one staff with his/her ADLs; wheelchair mobility when out of bed, dressing, bathing; -Extensive assistance of one with his/her meals, toileting, and bed mobility, non-ambulatory; -Two person assist for transfer may use Hoyer (full body mechanical lift) if needed. Review of the resident's ePOS, dated July 2024, showed an order dated 1/18/24, for regular diet, regular texture, and regular consistency. Prefers finger foods; any hard, crunchy meats mechanical soft. Observation and interview of the resident, showed: -On 7/9/24 at 8:01 A.M., 7/10/24 at 7:39 A.M., 7/11/24 at 9:14 A.M., 7/15/24 at 8:15 A.M., and 7/16/24 at 8:25 A.M., showed the resident had long nails that were approximately one inch in length. There was a thick buildup of dirt that also included red colored buildup underneath the resident's thumb on the right hand. The resident had food crumbs on his/her hands. The resident said staff keep him/her clean and dry and did not have complaints. The resident said he/she had a stroke and his/her left side was affected. He/She eats his/her food with his/her hands; -On 7/8/24 at 12:22 P.M. and 4:46 P.M., and 7/15/24 at 8:15 A.M., showed the resident was served finger foods. He/She ate meals without utensils using his/her right hand. During an interview on 7/16/24 at 8:40 A.M. CNA V said if the resident receives a bed bath, they are supposed to do nail care if the resident allows it and if they are not a diabetic. There is an activity aide that comes on weekends and cuts the resident's hair and shave them. 4. During an interview on 7/16/24 at 9:56 A.M., CNA DDD said staff are expected to complete nail care when the residents receive a bed bath. Residents #22 and #88 are easy to provide care for. Resident #22 can do more than what people think because he/she is contracted, but he/she can straighten out his/her legs. He/She is supposed to have his/her hair washed daily. Resident #88 needed to have his/her hair cut and washed. His/her nails are long and need to be cut. It is time for them to be cut. He/She would normally do it during evening shift because it is so hectic during day shift. 5. Review of Resident #51's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Impairment to the lower extremities; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Uses a wheelchair for mobility; -Maximal staff assistance needed for bathing, dressing, and personal hygiene; -Diagnoses: heart failure, stroke, vascular disease, kidney disease, diabetes, anxiety, and depression. Review of the resident's care plan, updated 9/12/24, showed: -Focus: the resident has a self-care deficit; -Goal: will improve current level of function; -Interventions: staff provide extensive assistance of two staff with dressing, mobility, showering and hygiene. During an interview on 7/8/24 at 9:13 A.M., the resident said he/she had not received routine showers. At times, staff provided a bed bath, he/she preferred a shower. Staff had told him/her there was not enough staff to provide showers. Review of the resident's shower sheets, showed no documented showers had been provided in June 2024 or July 2024. During an interview on 7/9/24 at 1:36 P.M., LPN A said the CNAs are responsible to complete the assigned showers, per the shower schedules. Staff have struggled to complete assigned showers and may complete a bed bath. Residents should receive showers twice a week. During an interview on 7/10/24 at 9:05 A.M., LPN L said all facility residents should receive a shower twice a week. Bed baths should be given if the resident elected one. Staff are often very busy and unable to provide showers to residents. The aides should follow the shower schedule daily. The nurses fill out the daily shower schedule. The aides should notify the nurses if a shower is not completed. 6. Review of Resident #124's quarterly MDS, dated [DATE] showed the following: -Diagnoses of schizoaffective disorder, dementia, and major depressive disorder; -Moderately impaired cognition; -Independent with toileting. Observation on 7/8/24 at 9:06 A.M., showed the resident in bed sitting on his/her bed. The resident's linen stained with yellow liquid and brown matter. The linen had a urine and bowel movement odor. Eight flies were observed on the resident's linen and flying around the bed. Observation on 7/9/24 at 7:26 A.M., showed the resident's linen was stained with yellow liquid and brown matter. The linen had a urine and bowel movement odor. Flies were observed on the resident's linen and flying around the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/10/24 at 9:27 A.M., showed the resident's bed linen was observed to have been changed. During an interview on 7/10/24 at 9:27 A.M., the resident said he/she was glad his/her bed linen had been changed and that it had not been changed for at least three days. During an interview on 7/15/24 at 2:41 P.M., CNA M said resident bedding should be changed every day. If staff observed the resident's linen to be soiled and covered with flies, the bedding should be changed immediately. During an interview on 7/15/24 at 2:49 P.M., LPN L said he/she believes staff are not changing the resident's bedding enough if flies were observed on and around the resident's bed and linen. Bedding should be changed at least once a day or when needed. During an interview on 7/16/24 at 11:37 A.M., the Director of Nursing (DON) and Administrator said they would expect resident's linen to be changed at least two times a week after the resident's shower or bed bath. They would also expect the bedding to be changed on an as needed basis. They would expect staff to immediately change the resident's bedding if it was observed to be soiled with flies on the bed. 7. During an interview on 7/9/24 at 8:45 A.M., CNA E said residents should receive showers at least twice weekly and as needed. If a resident does not want a shower, staff should try again later and offer a bed bath. If a resident refuses a shower, staff should try to offer different things to incentivize, such as offering a soda or something the resident likes. All showers should be documented on shower sheets. The CNA should sign off on the shower sheet and give it to the nurse for them to review. Upon completion, the shower sheets get placed in a folder at the nurse's station. 8. During an interview on 7/9/24 at 1:46 P.M., LPN A said showers are scheduled twice a week. There is a shower schedule for staff to follow on day and evening shift. All showers should be documented on shower sheets. Once the shower is completed, the shower sheet is given to the nurse for review. 10. During an interview on 7/15/24 at 6:36 A.M., LPN II said showers are scheduled on day and evening shift. There is a shower schedule at the nurse's station for staff to follow. CNAs should document all showers on a shower sheet and sign off upon completion. The shower sheet is given to the nurse, who reviews the shower sheet. Completed shower sheets go in a folder at the nurse's station. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. During an 7/16/24 at 11:18 A.M., the Administrator and DON said showers are scheduled two times a week and a shower schedule is posted at the nurse's station on each floor. Some residents want more or less showers. The CNAs are expected to complete shower sheets and give them to the charge nurse or the DON/Assistant Director of Nursing (ADON) if there are concerns. The shower sheet should be signed by CNA, the nurse reviews it and signs the shower sheet. She would expect staff to trim nails. The DON said it can be done by the CNA unless the resident is a diabetic. They are expected to report if the resident had any skin issues or the reason why it was not completed. If showers and bed care was not completed, staff are expected to report it to nursing. The CNAs can also shave the residents, but it is case by case as generalized shaving is facial care. Aides are expected to shampoo the resident's hair and document it on the shower sheet. If the resident refuses the initial attempt, they can come back 30 minutes later. If the resident continues to refuse, staff are to give them more time. If they are irate, the nurse is expected to document the refusal. Staff are expected to have incentive if applicable to get the resident to shower. They are expected to try different methods. MO00235408 MO00236928 MO00237997 MO00238490 37672 40290 46888

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 35394 37672 Based on observation, interview and record review, the facility failed to obtain and follow physician orders for wound care for two sampled residents (Residents #89 and #72). Both residents required hospitalization for assessment and treatment of wound conditions, including amputations. The census was 151. The Administrator was notified on 7/12/24 at 10:49 A.M., of an immediate jeopardy (IJ) that began on 7/1/24. The IJ was removed on 7/12/24 as confirmed by surveyor on-site verification. Review of the wound management policy, revised 10/24/22, showed: -Purpose: To provide a system for the treatment and management of residents with wounds including non-pressure ulcers; -Definitions: -Arterial Ulcer- an ulceration that occurs as the result of arterial occlusive disease when no pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis (death). Arterial/ischemic (lack of blood flow) ulcers may be present in persons with moderate to severe peripheral vascular disease (PVD, poor blood flow in the lower extremities), generalized arteriosclerosis (stiffening and thickening of the blood vessels) or vascular disease elsewhere. The arterial ulcer is characteristically painful, usually occurs in the distal (farther area) portion or the lower extremity, and may be over the ankle or bony area of the foot; -Procedure: -Assessment: -A licensed nurse will perform a skin assessment upon admission, re-admission, weekly and as needed (PRN) for each resident; -Upon identification of a new wound the licensed nurse will: -Measure the wound (length, width, depth); -Initiate a wound monitoring record sheet; -A wound monitoring record will be completed for each wound; -If the wound monitoring record is not used, documentation will be recorded within the medical record which may include nursing notes, treatment records or care plans; -Implement a wound treatment per physician's order; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An assessment of care needs for wound management will be made with emphasis on, but not limited to: -Identifying risk factors; -Treatment; -Mechanical off-loading and pressure reducing devices; -Reducing skin friction, sheer and moisture; -Nutritional status; -Evaluating and modifying interventions for a resident with an existing skin injury; -Wound management: -The physician will be notified to advise on appropriate treatment promptly; -The nurse will notify the responsible party of the presence of a skin injury; -Dietary contact will be made for nutritional assessment; -Rehabilitation services will be contacted for appropriate devices or pressure redistributing devices; -A nurse will develop a care plan for the resident based on recommendations from dietary, rehabilitation and the physician; -Per physician order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management; -Per attending physician order, the nursing staff will initiate treatment and utilize interventions for wound management; -The attending physician and interdisciplinary team (IDT) will be notified of: -New wounds; -Wounds that do not respond to treatment; -Wounds that increase in size; -Complaints of increased pain, discomfort or decrease in mobility; -Signs of ulcer sepsis (infection), odor, necrosis, if not already noted by the attending physician; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Certified Nurse Aides (CNA) will complete body checks on resident shower days and report unusual findings to the nurse; -Documentation: -New wounds will be documented on the 24 hour log and incident report will be completed by the nurse; -Wound documentation will occur a minimum of weekly until the wound is healed. Documentation will include: -Wound location; -Length, width and depth measurements in centimeters (cm); -Direction and length of tunneling (wound extends deeper into the tissue) and undermining (separation of the wound edges from the surrounding healthy tissue) if applicable; -Appearance of the wound base; -Drainage amount and characteristics including color, consistency and odor; -Appearance of wound edges; -Description of the peri-wound (skin surrounding the wound) condition or evaluation of the skin adjacent to the wound; -Presence or absence of new skin growth at wound rim; -Presence of pain; -IDT will document discussion and recommendation for: -Wounds that do not respond to treatment; -Wounds that worsen or increase in size; -Complaints or increased pain, discomfort or decrease in mobility by a resident; -Signs of ulcer sepsis, presence on drainage, odor or necrosis; -Residents refusing treatment; -Nurses will document effectiveness of current treatment in the medical record on a weekly basis; -Document notifications follow a change in skin condition; -Update the care plan as necessary. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident #89's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/1/24, showed: -No cognitive impairment; -No behaviors; -Diagnoses included heart failure, high blood pressure, diabetes, malnutrition, anxiety, bipolar (episodes of emotional highs and lows), and asthma; -Has surgical wounds; -Receives oxygen; -Uses wheelchair; -No Range of Motion (ROM) to the upper and lower right and left extremity; -Occasionally incontinent of bowel and bladder; -Weight: 445 pounds; -Skin and ulcer treatments: -Pressure reducing device for chair; -Pressure reducing device for bed; -Nutrition or hydration intervention to manage skin problems; -Surgical wound care; -Application of nonsurgical dressings (with or without topical medications) other than to feet; -Applications of ointments/medications other than to feet. Review of the care plan, in use during survey, showed: -Focus: Resident is resistive to care related to wound healing and ADLs; he/she has been observed removing his/her dressings to his/her foot and abdomen/chest; -Goal: Will cooperate with care; -Interventions: Education provided on cleanliness of his/her dressings and skin/hygiene; -Reported; he/she will pick at his/her wounds to his/her abdomen and chest placing removed skin and tissue into his/her mouth. States that he/she is cleaning off his/her fingers to prevent smearing blood onto his/her clothing; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff to educate and remind him/her importance of leaving his/her dressings in place until time for changes; -Focus: He/She is on antibiotic therapy related to infection. Doxycycline (treat and prevent infections) Hyclate Oral Tablet 100 milligrams (mg). Give 100 mg by mouth two times a day for infection until 5/12/24; -Goal: He/She will be free of any discomfort or adverse side effects of antibiotic therapy; -Interventions: Administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness every shift; -Monitor/document/report as needed adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia (loss of appetite), and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat); -Monitor/document/report as needed signs/symptoms of secondary infection related to antibiotic therapy: oral thrush (white coating in mouth, tongue), persistent diarrhea, and vaginitis/itchy perineum/whitish discharge/coating of the vulva/anus; -Focus: He/She has potential/actual impairment to skin integrity; -Abdomen midline: Trauma; -Sternum: Trauma; -Right groin abscess,1/20/24, full thickness; -Anterior nose, full thickness: Resolved 5-15-24; -Right shin, cellulitis (skin infection): Resolved 5-29-24; -Left thigh; -Goal: Affected areas will show adequate progress towards healing; -Interventions:11/20/23: Chest wound bleeding due to the resident scratching at site. Education provided by nurse and wound nurse in importance of not scratching at site; -6/19/2024: Multivitamin plus minerals daily; -6/19/2024: Pro stat (protein supplement) 30 milliliters (ml) by mouth, twice a day for skin integrity; -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; -Educate resident/family/caregivers of causative factors and measures to prevent skin injury; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Encourage good nutrition and hydration in order to promote healthier skin; -He/She needs pressure relieving mattress to protect the skin while in bed; -He/She needs pressure relieving cushion to protect the skin while up in chair; -Keep skin clean and dry. Use lotion on dry skin; -Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration (softening of the skin due to moisture) to physician; -Treatment per physician's orders. -Weekly treatment documentation; -Wound care to evaluate and treat as indicated; -Focus: Resident has diabetic ulcer of the right lateral foot, left heel related to diabetes, lack of sensation to affected area, and poor glycemic control; -Goal: Affected areas will show adequate progress towards healing through; -Interventions: 10/26/23: Arterial Doppler with ankle brachial index (ABI, compares the blood pressure in the upper and lower limbs) for bilateral symptoms: Pain, edema, skin breakdown, with chronic non-healing wound with drainage to right foot. Diagnosis of ulcer of limb/non-healing wound; -Avoid mechanical trauma: Constrictive shoes, cutting and trimming corns and calluses, adhesive tapes, improper shaving, and vigorous massage; -Monitor blood sugar levels; -Monitor/document wound: Size, depth, and margins: peri wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, and gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated; -Monitor/document/report as needed any signs/symptoms of infection: [NAME] drainage, foul odor, redness and swelling, red lines coming from the wound, excessive pain, and fever; -Monitor/document/report as needed changes in wound color, temperature, sensation, pain, or presence of drainage and odor; -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations; -Wound care to evaluate and treat as indicated; -Focus: He/She has bladder incontinence, activity intolerance, impaired mobility, poor toileting habits; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Goal: Resident will be continent during waking hours and he/she will remain free from skin breakdown due to incontinence and brief use; -Interventions: Brief use: Resident uses disposable briefs. Change as needed; -Clean perineal area (peri-area, area between the genitals and the anus) with each incontinence episode; -Encourage fluids during the day. Review of the resident's electronic physician order sheet (ePOS), showed: -An order, dated 5/6/24: wound care to right foot, cleanse with normal saline (NS) or Vashe (wound cleanser), pat dry, apply Santyl (used to remove dead tissue), nickel thick, edge to edge of wound bed, cover with calcium alginate (dressings are used on moderate to heavily exudative wounds during the transition from debridement to repair phase of wound healing) cut to fit cover with bordered gauze every day shift and as needed for soiling and unscheduled removal; -An order, dated 5/6/24: wound treatment to groin. Cleanse with Vashe, pat dry, apply Santyl nickel thick, edge to edge to wound bed, cover with calcium alginate cut to fit, cover with abdominal (ABD) pad every day shift and as needed for soiling and unscheduled removal; -An order, dated 6/19/24: Pro stat, 30 ml by mouth, twice a day for skin integrity; -An order, dated 6/27/24: for size E Tubi grips (elasticated, multi-purpose bandage used for compression) to bilateral feet for dressing security; -An order, dated 6/30/24: Wound care to left heel: Cleanse back of left heel with Vashe, pat dry, apply Santyl to wound bed only, apply calcium alginate to wound bed, only then cover with border gauze dressing every day shift for wound care management and as needed for wound care management for soiling and unscheduled removal; -An order, dated 7/3/24: Doxycycline Hyclate Oral Tablet 100 mg. Give one tablet by mouth two times a day related to cellulitis of unspecified part of limb for seven days; -An order, dated 7/3/24: for Levofloxacin (Levaquin, antibiotic) 750 mg. Give one tablet by mouth every evening shift for wound for seven days; -An order, dated 7/3/24: arterial Doppler (ultrasound to check blood flow in large arteries and veins) to right lower extremity for wound; -An order, dated 7/3/24: Wound care: Sternum (long, flat bone of the chest). Cleanse with wound cleanser or NS, pat dry, apply silicon bordered gauze every three days, every day shift for wound care. Chart nurse's notes if patient removes dressings and picks at open areas and as needed for soiling or unscheduled removal; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order, dated 7/4/24: Wound care: Abdomen midline. Cleanse with Vashe, pat dry, apply xeroform (sterile, fine mesh gauze) to wound bed only, then apply silicone bordered gauze, every day shift, every three days for wound treatment. Chart in nurse's notes if patient removes dressings and picks at wounds and as needed for soiling and unscheduled removal; -An order, dated 7/6/24: Mupirocin external ointment (used to treat secondarily infected traumatic skin lesions) 2 percent (%). Apply to right hand/third digit topically two times a day for paronychia (infection of the tissue adjacent to a nail) until 7/12/24. Soak right hand third digit in soapy water, dry, and apply ointment; -An order, dated 7/6/24: Right third finger: Paronychia. Soak right hand and fingers in warm soapy water for 15 minutes, dry, apply mupirocin ointment two times a day for infection of right hand third digit Paronychia until 07/12/2024, twice daily and PRN; -No treatment orders for the Abdomen right lower quadrant. Review of the resident's June 2024 Treatment Administration Record (TAR), showed: -An order, dated 6/1/24: Treatment: Left Heel: Cleanse back of left heel with NS, pat dry, apply calcium alginate and cover with border gauze dressing every day shift for wound care management. Entries on 6/1, 6/4, 6/11, 6/14, 6/15, 6/17, 6/22, 6/27, and 6/28/24 were blank. It was discontinued on 6/29/24; -An order, dated 6/1/24: Wound: Left thigh. Cleanse with NS, pat dry, apply calcium alginate, and cover with border gauze dressing every day shift. Entries on 6/1, 6/4, 6/11, 6/14, 6/15, 6/17, 6/22, 6/27, 6/28, and 6/28/24 were blank. The order was discontinued on 6/29/24; -An order, dated 5/7/24: Wound: Right foot. Cleanse with NS or Vashe, pat dry, apply Santyl nickel thick edge to edge of wound bed, cover with calcium alginate cut to fit cover with bordered gauze every day shift. Entries on 6/1, 6/4, 6/11, 6/14, 6/15, 6/17, 6/22, 6/27, and 6/28/24 were blank; -An order, dated 6/1/24: Wound: Abdomen midline. Cleanse with wound cleanser or NS, pat dry, apply bordered gauze every day shift for wound treatment. Entries on 6/1, 6/4, 6/11, 6/14, 6/15, 6/17, 6/22, 6/27, and 6/28/24 were blank; -An order, dated 5/7/24: Wound treatment: Groin. Cleanse with Vashe, pat dry, apply Santyl nickel thick edge to edge to wound bed, cover with calcium alginate cut to fit, cover with ABD pad every day shift. Entries on 6/1, 6/4, 6/11, 6/14, 6/15, 6/17, 6/22, 6/27, and 6/28/24 were blank; -An order, dated 6/1/24: Sternum. Cleanse with wound cleanser or NS pat dry apply bordered gauze every day shift. Entries on 6/1, 6/4, 6/11, 6/14, 6/15, 6/17, 6/22, 6/27, and 6/28/24 were blank. Review of the progress notes, showed: -On 6/3/24 at 11:03 A.M., Nurse Practitioner (NP) notified of wound care not done on 5/31/24 and 6/1/24. No new orders received at this time; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 6/10/24 at 12:12 P.M., NP notified of the refusal of all medications and care on 6/8/24 and 6/9/24. No new orders received at this time; -On 6/11/24 at 12:22 P.M., NP notified of missing wound care and Santyl and rivaroxaban (blood thinner) on 6/10/24. No new orders received at this time; -On 6/12/24 at 11:30 A.M., NP notified of missing wound care on 6/11/24. NP also notified of resident being hospitalized with medications for missing medications after day shift 6/11/24; -On 6/15/24 at 12:45 P.M., NP notified of missing wound care and insulin injections on 6/14/24. No new orders received; -On 6/16/24 at 4:29 P.M., NP notified of missed medication (lactulose, treats constipation and liver disease) and wound care on 6/15/24. No new orders received at this time; -On 6/18/24 at 12:15 P.M., NP notified of missed wound care on 6/17/24. Care ongoing, no new orders received; -On 6/24/24 at 12:12 P.M., NP notified of missing wound care on 06/22/24. Care ongoing, no new orders received; -On 6/29/24 at 10:32 A.M., NP notified of missing wound care on 6/27/24 and 6/28/24. Care ongoing, no new orders received. Review of the wound report, dated 6/26/24, showed: -Abdomen- midline: Trauma; -Measurement: 11.4 cm x 4.7 cm x 0.3 cm; -Acquired; -Sternum: Trauma; -Measurement: 2.8 cm x 4 cm x 0.2 cm; -Acquired; -Right groin: Full thickness (damage extends below the epidermis and dermis (all layers of the skin) into the subcutaneous tissue (fat) or beyond (into muscle, bone, or tendons); -Measurement: 1.2 cm x 1.2 cm x 0.2 cm; -Acquired; -Right lateral foot: Diabetic [NAME] (system for classifying diabetic ulcers) grade 2 (Deep ulcer without abscess or osteomyelitis); (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Measurement: 3.9 cm x 5.9 cm x 0.3 cm; -No documentation of acquired or admitted with; -Left heel: Diabetic [NAME] grade 2; -Measurement: 3.2 cm x 4.1 cm x 0.5 cm; -No documentation of acquired or admitted with; -Left thigh: Resolved. Review of the resident's July 2024 TAR, showed: -An order, dated 5/6/24: wound care to right foot cleanse with NS or Vashe, pat dry, apply Santyl, nickel thick, edge to edge of wound bed, cover with calcium alginate cut to fit cover with bordered gauze every day shift. Treatment marked as other/see progress notes on 7/1 and 7/2/24; blank entries on 7/4 and 7/5/24; -An order, dated 5/6/24: wound treatment to groin. Cleanse with Vashe, pat dry, apply Santyl nickel thick, edge to edge to wound bed, cover with calcium alginate cut to fit, cover with ABD pad every day shift. Treatment marked as other/see progress notes on 7/1 and 7/2/24; blank entries on 7/4 and 7/5/24; -An order, dated 6/30/24: Wound care to left heel: Cleanse back of left heel with Vashe, pat dry, apply Santyl to wound bed only, apply calcium alginate to wound bed, only then cover with border gauze dressing every day shift for wound care management and as needed. Treatment marked as other/see progress notes on 7/1 and 7/2/24; blank entries on 7/4 and 7/5/24; -An order, dated 7/3/24: Wound care: Sternum. Cleanse with wound cleanser or NS, pat dry, apply silicon bordered gauze every three days, every day shift for wound care. Chart nurse's notes if patient removes dressings and picks at open areas and as needed for soiling or unscheduled removal; blank entry on 7/4/24. -An order, dated 6/1/24: Wound care: Sternum. Cleanse with wound cleanser or NS, pat dry, apply bordered gauze every day shift. Treatment marked as other/see progress notes on 7/1 and 7/2/24. Treatment administered on 7/3/24 and discontinued on 7/3/24; -An order, dated 7/4/24: Wound care: Abdomen midline. Cleanse with Vashe, pat dry, apply xeroform to wound bed only, then apply silicone bordered gauze, every day shift, every three days for wound treatment. Chart in nurse's notes if patient removes dressings and picks at wounds and as needed; blank entries on 7/4/24 for scheduled treatment; -An order, dated 6/30/24: Wound care: Abdomen midline. Cleanse with Vashe, pat dry, apply silicone bordered gauze every day shift. Treatment marked as other/see progress notes on 7/1 and 7/2/24. Treatment was administered on 7/3/24 and discontinued on 7/3/24. Review of the progress notes, showed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 7/1/24 from 12:12 to 12:14 P.M., the resident refused wound treatments to the following areas: -Abdomen midline: -Left heel: -Groin. -Right foot -Sternum. -On 7/2/24 from 2:38 P.M. to 2:39 P.M., health care provider (HCP) notified by this nurse, he/she was not able to carry out treatment orders; physically impossible related to nurse to patient ratio for the following treatment areas: -Abdomen midline: -Left heel: -Groin. -Right foot -Sternum. Review of the wound report, dated 7/3/24, showed: -Abdomen- midline: Trauma; -Measurement: 19.7 cm x 9.9 cm x 0.2 cm; -Acquired; -Sternum: Trauma; -Measurement: 1.5 cm x 2.0 cm x 0.2 cm; -Acquired; -Right groin: Full thickness; -Measurement: 1.3 cm x 1.6 cm x 0.2 cm; -Acquired; -Right lateral foot: Diabetic [NAME] grade 2; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Measurement: 3.8 cm x 5.2 cm x 0.3 cm; -Acquired; -Left heel: Diabetic [NAME] grade 2; -Measurement: 3.5 cm x 2.0 cm x 0.2 cm; -Acquired; -Abdomen, Right lower quadrant: Trauma; -Measurement: 3.9 cm x 3.3 cm x 0.2 cm; -Acquired. Review of a wound care note, dated 7/3/24, showed: Wound care NP rounded with Licensed Practical nurse (LPN) S to discuss with staff importance of treatment changes, and skin care. Wound culture pending. Spoke with the physician regarding wound. Physician recommends levofloxacin 750 mg once daily for seven days. Nurse to ensure that treatment are being changed daily. Arterial Doppler with ABI. MolecuLight (wound imaging device that allows clinicians to visualize bacteria and measure wounds) positive of bacteria. Debridement (removal of damaged tissue) completed. Treatment plan updated. Observation and interview on 7/8/24 at 9:39 A.M., showed the resident in bed, calling out for help. He/She sat up in bed, attempting to get up, but was unsuccessful. He/She did not have clothing on. He/She appeared obese with a pannus stomach (extra skin and fat deposits hang from the stomach or belly area on the abdomen) with several wounds that were actively bleeding onto to the floor. One wound appeared to be large, dark, and necrotic on the lower part of the stomach. The resident said he/she was unable to get up and was not able to hit his/her call light because it was stuck. Observation of the call light showed the cord was wrapped up and underneath the leg of a night table. The DON entered the room to assist the resident. The resident said it was an hour since nursing last checked on him/her. There was a room odor of urine, and resident's bed and sheets were wet. The DON closed the resident's door. The resident told the DON that he/she had not received any treatments in four days. At 9:48 A.M., the resident sat in his/her wheelchair across from his/he bed. He/She said staff were able to assist him/her to his/her wheelchair. He/She was bleeding on the abdomen because he/she had wounds on his/her stomach and did not get treatments in the last four days. The resident lifted up his/her gown and showed several wounds, size ranging from pen size to approximately two inches in length, that were red, inflamed and bleeding. He/She was told staff would be in to do his/her treatment. Flies were observed in the room. There was an odor of urine and feces in the room. Dried blood noted on the floor next to the resident's bed. At 11:58 A.M., the resident sat in the hall across from the nurse's station. The resident had a bedside table in front of him/her and ate his/her meal. Staff said the resident wanted to go to the hospital. At 12:23 P.M., the resident sat in his/her wheelchair across from the nurse's station. He/She wore a hospital gown with his/her pannus exposed from underneath the hospital gown. The lower stomach had weeping with a large amount of clear fluid that dripped onto the floor. Both feet were wrapped and the resident wore shoes. The resident said he/she was going to the hospital because of his/her feet. Emergency Medical Technicians (EMTs) arrived and assisted the resident with standing and pivoting to the stretcher from his/her wheelchair. At 12:27 P.M., the EMTs lifted the stretcher and resident was taken into the elevator. (continued on next page)

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Hillside Rehab and Healthcare Center	1265 McLaran Avenue Saint Louis, MO 63147

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the progress notes, showed: -On 7/8/24 at 12:00 P.M., NP notified of missing wound care on the dates of 7/5/24, 07/6/24, and 07/7/24. Care on-going, no new orders received; -On 7/8/24 at 6:03 P.M., the resident was escorted via gurney by four persons to hospital due to infection to wounds; -At 6:05 P.M., resident alert and oriented upon leaving the facility, noted clear drainage from the abdomen with cavity continuously draining. During an interview on 7/9/24 at 10:26 A.M., NP X said he/she has seen the resident's wounds when they were exposed. There is a wound nurse that comes in and changes the dressings. At the time, the resident had cellulitis and he/she was given medications. He/she had wounds on his/her right leg. Sometimes he/she needed intravenous (IV) antibiotics, but not recently. The wound nurse was taking care of him/her. NP X had not been notified of the resident's missed treatments; the specialized wound NP would get notified. NP X did not know about the changes with the resident's Levaquin order. He/She was not aware of the Doppler that was missed on 7/5/24. He/She would expect staff to notify the physician, reschedule and document it. He/She would expect all orders to be followed and treatments to be completed timely and as needed. During an interview on 7/10/24 at 7:47 A.M., Certified Medication Technician (CMT) OO said he/she sent the resident to the hospital in the past. The resident scratches his/her stomach a lot. He/She does not like to take care of him/herself, and does not like showers. The resident's nails get dirty from scratching, CMT OO offered to give the resident a shower. CMT OO observed the resident's stomach and it was bleeding, and there were no bandages. CMT OO and the wound nurse applied the wound treatments at that time. During an interview on 7/10/24 at 7:58 A.M., Certified Nurse Aide (CNA) TT said he/she had worked for the facility for two weeks. If he/she were to find any wounds or skin issues, he/she would report it to the nurse. During an interview on 7/10/24 at 9:11 A.M., a Registered Nurse (RN) at the hospital said the resident was currently on IV medications, Vancomycin (antibiotic), Cefepime (treats bacterial infections), and Flagyl (antibiotic). Incision and drainage (I&D) to both of his/her feet will be completed, but there were no orders for surgery. The physicians have talked about surgery as an option. The resident's abdomen is very inflamed, and he/she had developed cellulitis. The nurse was in the room with the hospital wound care team during the treatment and the resident's stomach was still draining, red, inflamed, scaling on the outside skin, but it was oozing from the wound. The I&D will possibility occur on 7/10/24. The nurse added that the hospital staff wondered how the resident's stomach became so itchy and irritated. The wound culture was still pending. Review of the hospital record, dated 7/9/24, showed: -Reason for consult: Foot wounds worsening; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident with a past medical history (PMH) of resected atrial myxoma (tumor that is found in the top chambers of the heart), bipolar disease, factor five Leiden (blood clot disorder), deep vein thrombosis (DVT, blood clots), open heart surgery, high blood pressure, obstructive sleep apnea (OSA), personality disorder, type two diabetes, morbid obesity, presented from nursing home with complaints of wounds to his/her bilateral feet that are painful and have purulent drainage. He/She has chills and fever. He/She also has some abdominal skin wounds over his/her stomach. He/She states he/she scratches his/her abdomen a lot. We are being asked to see patient in consultation for further evaluation of his/her wounds; -Assessment/Plan: Bilateral diabetic foot wounds and abdominal wounds: -Check blood culture; -Vancomyacin, Cefepime, Flagyl, I&D, and surgery consult; -Wound nurse consults. During an interview on 7/10/24 at 9:35 A.M., the DON said LPN S is the treatment nurse. LPN S does the wounds on Monday through Friday and turns in the wound report to the DON. If LPN S is unavailable to complete treatments, the DON or Assistant Director of Nursing (ADON) would be available. The DON will let staff know if LPN S was not there. There are also two ADONs in the facility. It was reported the nurses were not able to complete treatments, but it only happened once. If the nurses cannot get the treatment done, they report it to the DON or the on-coming nurse if there is a shift change. The expectation is either of the nurses will do the wound care. The DON will assist nurses with wound care. The DON is working on enforcing that treatments are completed. Wounds that are not treated can result in sepsis, infection, injury, or death. She would expect there to be a progress note if the resident refuses care and staff should call the physician. She would speak to the resident and report it to the physician. It was reported the resident would take bandages off and pick at his/her wounds. They educated him/her to not take it off or pick. He/She would say, I am not going to stop. The DON told nursing to document it or if the resident would say no. The DON was not aware of lack of staffing being a reason the treatments were not completed. If it's an on-going issue, then staff need to document it. If the resident was scratching, staff should still do the wound care. If the resident says no, staff should document it and follow up. The DON did not know why the resident was ordered Levaquin and Doxycycline. The DON confirmed she saw the resident in his/her room prior to being transported to the hospital. When the DON observed the resident, he/she did not have on a gown. He/She sat on the bed and wanted to get into his/her wheelchair. She told the resident she would do his/her wound care. The resident wanted to go to the hospital for his/her foot. The DON wanted to look at it, but the resident said no. The DON ended up doing his/her treatment to the feet. His/her foot was necrotic. There was no odor and a moderate amount of clear drainage. He/she did not have complaints of pain. The resident did not have any bandages to his/her abdomen, but they were on his/her feet. The resident requested to go to the hospital as a first option even though the DON wanted to solve the issue. It was not reported to the DON that he/she missed treatments on 7/2/24. Nursing will have to be educated. During an interview on 7/10/24 at 1:25 P.M., the hospital RN said the resident had a positive wound culture. He/She had a blood infection. Infectious disease (ID) will monitor his/her antibiotics. He/She is scheduled for the I&D on Friday (7/12/24) on the feet. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 7/11/24 at 7:29 A.M., LPN S said he/she had been doing wound care in the facility since 6/13/24. He/She works Tuesday through Friday and every other weekend on the floor and he/she continues to complete the treatments. The nurses text LPN S when there is a new wound. The floor nurses are supposed to complete the skin assessments daily. It will pop up on the TAR to let them know the resident needs a skin assessment. The Nurses are expected to check the medical record before they leave in case there is a skin assessment due. Skin assessments are completed weekly. If aides see any issues, they are expected to notify the nurse, document on the assessment, and report to LPN S. Staff have said they will not do the treatments. If a resident is found without a treatment, he/she would expect the charge nurse should apply treatments if LPN S is not here. Staff should document if the resident refused and try to negotiate. If the wound is draining, he/she would expect to be notified and assess it. The reside

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37672 Based on interview and record review, the facility failed to ensure one resident received care consistent with professional standards and facility policy to prevent and/or treat pressure ulcers (a localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction). The facility failed to ensure wound treatments were completed as ordered, and failed to notify the attending wound Nurse Practitioner (NP) of the missed treatments. The resident was sent to the hospital and received a surgical debridement of a sacral (tailbone) wound. The facility failed to administer ordered antibiotics for a 6 week time frame, which were ordered by the hospital infectious disease (ID) physician (Resident #72). The sample size was 30. The census was 151. Review of the wound management policy, dated 10/24/22, showed: -Purpose: to provide a system for the treatment and management of residents with wounds including pressure ulcers; -Policy: a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing; -Definitions: -Pressure ulcer: any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers usually occur over bony prominences and re-graded or staged to classify the degree of tissue damage observed; -Wound management: -The attending physician will be notified to advise on appropriate treatment promptly; -The licensed nurse will notify the responsible party of a pressure ulcer; -Rehabilitation services will be contacted for appropriate devices or pressure redistributing devices; -Per physician orders, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management; -The physician and interdisciplinary team (IDT) will be notified of: -New pressure wounds; -Pressure wounds that do not respond to treatment; -Pressure wound that worsen or increase in size; -Complaints of increased pain, discomfort or decreased mobility by the resident; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Signs of wound sepsis (severe infection), presence of drainage, odor, necrosis (black, firm dead skin) if not already noted by the physician; -Residents who refused treatment; -Certified Nurse Aides (CNA) will complete body checks on the resident's shower days and report unusual findings to the nurse; -Documentation: A. New wounds will be documented on the 24 hour log and an incident report will be completed by the nurse; B. Wound documentation will occur weekly until the wound is healed. Documentation will include: -Wound location; -Length, width, and depth measurement recorded in centimeters (cm); -Direction and length of tunneling (wound extends deeper into the tissue than its surface, creating a channel) or undermining (separation of the wound edges from the surrounding healthy tissue, often creating a pocket under the wound surface); -Appearance of the wound base; -Drainage amount, characteristics such as color, consistency and odor; -Appearance of wound edges; -Description of the peri-wound (skin next to the wound) condition; -Presence of absence of new epithelium (skin) at the wound edge; -Presence of pain; C. IDT will document discussion and recommendations for: -Pressure wounds that do not respond to treatment; -Pressure wounds that worsen or increase in size; -Complaints of increased pain, discomfort of decrease in mobility by the resident; -Signs of sepsis, drainage, odor or necrosis; -Residents refusing treatment; D. Nurses will document effectiveness of current treatment in the medical record; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	E. Document notifications following a change in the resident's skin condition; F. Update the care plan as needed. Review of Resident #72's quarterly Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 4/9/24, showed: -Cognitively intact; -Staff provide substantial to maximal assistance for toileting, transfers, showers, dressing and bed mobility; -Diagnoses included heart failure, high blood pressure, diabetes, cerebral palsy (a group of conditions that affect movement and posture), malnutrition, anxiety and depression; -Has a Stage 1 pressure injury (observable, pressure related alteration of intact skin with non-blanchable redness of a localized area): 1; -At risk for pressure injury; -Unhealed pressure injury; -Stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat maybe visible, but bone, tendon or muscle is not exposed. Slough (yellow, stringy tissue) maybe present): 3 -Number present on admission or re-admission: 3; -Stage 4 pressure ulcer (full thickness loss, with exposed bone): 1 -Number present on admission or re-admission: 1 -Unstageable ulcer: (a wound that occurs due to prolonged pressure, full tissue loss which the depth of the wound of bed sore is completely obscured by eschar (black, dead tissue) number of unstageable ulcers: 1 -Number of these ulcers that were present on admission or re-admission: 0; -Skin and ulcer treatment: -Pressure reducing device for chair and bed; -Turn and repositioning program; -Nutrition and hydration interventions; -Pressure ulcer care; -Application of nonsurgical dressing other than to feet; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Application of ointments or medications other than to feet. Review of the May 2024, Treatment Administration Record (TAR), showed the following physician order: -An order, dated 3/16/24: Santyl ointment (used to remove dead tissue from a wound) 250 milligram (mg) to coccyx every day shift. Undocumented and blank on 5/1 and 5/2. Review of the progress notes, showed no documentation regarding the missed treatment or physician notification. Review of the facility wound report, showed on 5/3/24: -Location: Coccyx; -Stage: IV; -Treatment: Santyl, calcium alginate (highly absorptive dressing) and dressing; -Measurements: length (L) 6.9 centimeter (cm) x 9.8 width (w) cm x 0.6 depth (d) cm; -Acquired. Review of the May 2024, TAR, showed: -An order, dated 3/16/24: Santyl ointment 250 mg to coccyx every day shift. Undocumented and blank on 5/4; -An order, dated 5/7/24: Gentamycin ointment (topical ointment for bacterial skin infections) 0.1%, apply to coccyx every day shift for 30 days. Undocumented and blank on 5/7. Review of the progress notes, showed no documentation regarding the missed treatments or physician notification. Review of the facility wound report, dated 5/9/24, showed: -Location: Coccyx -Stage: IV; -Treatment: Santyl, calcium alginate and gentamycin; -Measurements: 6.8 cm (l) x 9.8 cm (w) x 1.5 cm (d); -Acquired. Review of the May 2024, TAR, showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Gentamicin ointment 0.1 %, apply to coccyx everyday shift for 30 days. Undocumented and blank on 5/10 and 5/15; -Santyl ointment 250 mg to coccyx every day shift. Undocumented and blank on 5/10. Review of the progress notes, showed on 5/13/24 at 2:48 P.M., a nurse note: NP notified about missing wound care on 5/10/24, 5/11/24 and 5/12/24. No new orders at this time. Review of the facility wound report, dated 5/15/24, showed: -Location: Coccyx -Stage: IV; -Treatment: Santyl, calcium alginate and gentamycin; -Measurements: 12.3 cm (l) x 6.6 cm (w) x 2.8 cm (d); -Acquired. Review of the specialized wound report, dated 5/16/24, showed: -Wound state: open; -Cause: Pressure; -Wound cause: at facility; -Measurements: 7.2 cm (l) x 8.6 cm (w) x 0.7 cm (d); -Tissue type: -Granulation type: 65 %; -Slough: 15 %; -Pressure versus non-pressure: -Is the patient or patient's body part immobile: yes; -Did nursing staff note it is directly from positioning: yes; -Was the patient's affected body part immobile recently (last 2 weeks) prior to wound development: yes; -Wound details: pressure ulcer/pressure injury; -Pressure injury: Stage IV; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Exudate volume: moderate: wound is wet and drainage covers 25-75 % of the dressing: -Exudate type: serosanguineous (clear, slightly blood tinged) drainage; -Undermining: yes from 12 o'clock to 2 o'clock position; -Wound orders: -Clean with saline or vashe (wound cleanser), use to irrigate and scrub the wound bed. Apply Santyl and calcium alginate to wound base, cut to fit inside the wound edges, do not place on skin. Cover with bordered gauze. Change daily, for soiling and saturation -Notes: Debridement to remove unhealthy tissue and stimulate healing; -Measurements post procedure: 7.4 cm (l) x 8.5 cm (w) x 1.0 cm (d). Review of the May 2024, TAR, showed: -Gentamicin ointment 0.1 %, apply to coccyx everyday shift for 30 days. Undocumented and blank on 5/18; -Santyl ointment 250 mg to coccyx every day shift. Undocumented and blank on 5/18. Review of the progress notes, showed: -On 5/21/24 at 12:25 P.M., a nurse note: NP notified of missing wound care on 5/18/24. No new ordered received; -On 5/21/24 at 5:57 P.M., a nurse note: call placed to pharmacy due to being out of gentamycin ointment for coccyx. The pharmacy stated would attempt to send two tubes as the wound needed more than 1 gm at dressing changes. The insurance may not cover, wound measurements sent to aid in obtaining medication. Gentamycin to arrive tomorrow morning due to pharmacy closing at 5:00 P.M. Review of the specialized wound progress note, dated 5/23/24, showed: -Wound state: open -Cause: Pressure; -Wound cause: at facility; -Measurements: 7.3 cm (l) x 9.3 cm (w) x 1.0 cm (d); -Tissue type: -Granulation type: 70%; -Slough 10%; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Pressure versus non-pressure: -Is the patient or patient's body part immobile: yes; -Did nursing staff note it is directly from positioning: yes; -Was the patients affected body part immobile recently (last 2 weeks) prior to wound development: yes; -Wound details: pressure ulcer/pressure injury; -Pressure injury: Stage IV; -Exudate volume: moderate: wound is wet and drainage covers 25-75% of the dressing: -Exudate type: serosanguineous drainage; -Peri-wound texture: friable (tissue that is easily irritated, more prone to inflammation and damage); -Length, width and depth: stayed the same compared to previous visit; -Undermining: yes from 12 o'clock to 2 o'clock position; -Wound orders: -Clean with saline or vashe, use to irrigate and scrub the wound bed. Apply Santyl and calcium alginate to wound base, cut to fit inside the wound edges, do not place on skin. Cover with bordered gauze. Change daily, for soiling and saturation. Review of the May 2024, TAR, showed: -Gentamicin ointment 0.1 %, apply to coccyx everyday shift for 30 days. Undocumented and blank on 5/27; -Santyl ointment 250 mg to coccyx every day shift. Undocumented and blank on 5/27. Review of the progress notes, dated 5/28/24 at 11:50 A.M., a nurse note: NP notified of missing wound care on 5/27/24. No new orders received. Review of the specialized wound progress note, dated 5/29/24, showed: -Wound state: open -Cause: Pressure; -Wound cause: at facility; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Measurements: 6.7 cm (l) x 12.6 cm (w) x 1.9 cm (d); -Tissue type: -Granulation type: 70%; -Slough 10%; -Pressure versus non-pressure: -Is the patient or patient's body part immobile: yes; -Did nursing staff note it is directly from positioning: yes; -Was the patients affected body part immobile recently (last 2 weeks) prior to wound development: yes; -Wound details: pressure ulcer/pressure injury; -Pressure injury: Stage IV; -Exudate volume: moderate: wound is wet and drainage covers 25-75% of the dressing: -Exudate type: serosanguineous drainage; -Peri-wound texture: friable; -Length, width and depth: stayed the same compared to previous visit; -Undermining: yes from 12 o'clock to 2 o'clock position; -Wound orders: -Clean with saline or vashe, use to irrigate and scrub the wound bed. Apply Santyl and calcium alginate to wound base, cut to fit inside the wound edges, do not place on skin. Cover with bordered gauze. Change daily, for soiling and saturation; -Assessment notes: debridement for removal of unhealthy tissue and promote wound healing; Wound measurement after debridement: 14.2 cm (l) x 10.6 cm (w) x 6.7 cm (d). Debrided 60%. Review of the facility wound report, dated 5/30/24, showed: -Location: Coccyx -Stage: IV; -Treatment: Santyl, calcium alginate and gentamycin; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Measurements: 6.7 cm x 12.6 cm x 1.9 cm; -Acquired. Review of the progress notes, showed on 5/30/24 at 9:48 A.M.: a nurse note: care plan held and discussed medical decline. Guardian agreed to hospice services. Review of the May 2024 TAR, showed: -Gentamicin ointment 0.1 %, apply to coccyx every day shift for 30 days. Undocumented and blank on 5/31; -Santyl ointment 250 mg to coccyx every day shift. Undocumented and blank on 5/31 Review of the progress notes, dated 6/1/24 at 10:53 P.M., showed a nursing note: resident experienced vomiting and left sided abdominal pain. Resident requested to go to the hospital. Per physician, send to the hospital for evaluation and treatment. Review of hospital discharge summary, dated 6/8/24, showed: -Overview: admitted : 6/2/24; -discharged : 6/8/24; -Problems: -Active problem: decubitus ulcer, Stage 4 with infection; -Details of hospital stay: -Chronic osteomyelitis (bone infection) of the sacrum (coccyx) post multiple debridements with wound vacuum, who presented to the emergency department (ED) with abdominal pain. The legal guardian stated he/she was concerned regarding the pain and worsening wound. The patient was noted to be hypotensive (low blood pressure). Upon ED arrival, found to have sepsis (blood infection) and increasing sacral ulcer size and could not rule out sacroiliac septic arthritis. Wound cultures were obtained and sent. The patient was administered broad spectrum antibiotics. Surgical team was consulted and patient was taken to the operating room for debridement; -Hospital course: -Sepsis: infected sacral ulcer; -Osteomyelitis: chronic osteomyelitis of sacrum with multiple surgical debridements of the sacral ulcer. Imaging showed mild enlargement of sacral ulcer. On 6/4/24 surgical debridement. Wound care service placed wound vacuum. Infectious diseases guided antibiotic treatments and bone culture positive for multiple bacterium. Antibiotics at discharge Doxycycline 100 mg twice a day for two weeks and Ciprofloxacin (antibiotic) and Flagyl (antibiotic) for six weeks; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Post discharge: wound vac care and ordered blood testing in six weeks. Fax results of ordered blood testing to infectious diseases; -Discharge to long term facility. Review of the facility re-admission progress note, showed: -On 6/8/24 at 8:36 P.M.: readmitted from hospital today at 3:45 P.M. Oriented to person, place and time. Resident is bedfast. The physician/NP approves of the plan of care; -On 6/9/24 at 9:53 P.M., give metronidazole (antibiotic) 500 mg, give one tablet 3 times a day for wound. On order, new prescription; -On 6/9/24 at 4:52 A.M., the resident had new order for antibiotic, still awaiting on call back from physician to verify orders; -On 6/9/24 at 2:52 P.M.: an order: wound to coccyx, cleanse with normal saline or vashe, pat dry, apply Santyl nickel thick edge to edge of the wound bed, apply Gentamycin ointment to wound bed, cover with calcium alginate, cut to fit, cover with bordered gauze, for every day shift. Physician called and orders unable to be verified, a protective covering applied instead; -On 6/9/24 at 7:42 P.M., spoke to the physician and he does not want a stop date on the two antibiotics; -On 6/9/24 at 9:39 P.M., Doxycycline 100 mg, take two time a day for 14 days, Ciprofloxacin 750 mg twice a day, order needs to be verified; Review of the June 2024 MAR and TAR, showed: -On 6/9/24: Ciprofloxacin 750 mg, Doxycxyline 100 mg and Metronidazole 500 mg not administered; -On 6/9 and 6/10/24: Santyl ointment 250 mg, not administered on 6/9 and 6/10: -On 6/9/24: Coccyx clean with NS apply Santyl nickel thick, apply Gentamycin to wound bed, cover with calcium alginate cut to fit, cover with bordered gauze, every day shift. Not administered, noted as blank. Review of the progress notes, showed: -On 6/10/24 at 2:54 P.M., Santyl ointment 250 mg, apply per TAR every day shift for 30 days. On order; -On 6/11/24 at 12:23 P.M., NP notified of missed wound care and Santyl administration on 6/10/24. No new orders given; -On 6/12/24 at 11:30 A.M., NP notified of missed wound care on 6/11/24. No new orders received. Review of the June 2024 MAR and TAR, showed: (continued on next page)

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	265585	A. Building B. Wing	07/16/2024

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 6/14/24: Ciprofloxacin 750 mg, Doxycxyline 100 mg and Metronidazole 500 mg not administered; -On 6/14/24: Coccyx clean with NS apply Santyl nickel thick, apply Gentamycin to wound bed, cover with calcium alginate cut to fit, cover with bordered gauze, every day shift. Noted as blank. Review of the progress notes, showed: -On 6/15/24 at 12:44 P.M., NP notified of missed wound care on 6/14/24. No new orders received; -On 6/16/24 at 4:24 P.M., NP notified of missed wound care on 6/15/24. No new orders received. Review of the June 2024 MAR and TAR, showed: -On 6/17/24: Ciprofloxacin 750 mg, Doxycxyline 100 mg and Metronidazole 500 mg not administered. Noted as blank; -On 6/17/24: Coccyx clean with NS apply Santyl nickel thick, apply Gentamycin to wound bed, cover with calcium alginate cut to fit, cover with bordered gauze, every day shift. Not administered. Review of the progress notes, showed: -On 6/17/24 at 7:47 P.M., Ciprofloxacin 750 mg on order; -On 6/18/24 at 12:12 P.M.,: NP notified of missed wound care on 6/17/24. No new orders. Review of the ePOS, showed a note on 6/19/24: Ciprofloxacin 750 mg: NP states 8 days was long enough for medication. Review of the progress notes on 6/19/24, showed no documented order or NP visit note regarding the discontinuation of the ordered Ciprofloxacin 750 mg antibiotic. Review of the June 2024 MAR and TAR, showed: -On 6/22/24: Ciprofloxacin 750 mg stopped on 6/19/24, Doxycxyline 100 mg and Metronidazole 500 mg not administered; -On 6/22/24: Coccyx, clean with NS apply Santyl nickel thick, apply Gentamycin to wound bed, cover with calcium alginate cut to fit, cover with bordered gauze, every day shift. Not administered. Review of the progress notes, showed on 6/24/24 at 12:09 P.M., NP notified of missed wound care on 6/22/24. No new orders given. Review of the June 2024 MAR and TAR, showed: -On 6/27/24 and 6/28/24: Ciprofloxacin 750 mg, Doxycxyline 100 mg and Metronidazole 500 mg not administered; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-On 6/27/24 and 6/28/24: Coccyx clean with NS apply Santyl nickel thick, apply Gentamycin to wound bed, cover with calcium alginate cut to fit, cover with bordered gauze, every day shift. Noted as blank. Review of the progress notes, showed: -On 6/29/24 at 10:30 A.M.,: NP notified of missed wound care on 6/27 and 6/28/24. No new orders given; -7/2/24 at 2:28 P.M.,: Coccyx wound: physician notified writer unable to carry out wound care orders related to nurse to resident ratio; -On 7/7/24 at 5:07 P.M.,: nurse notified by aide that resident's catheter (hollow tube placed in the bladder to drain urine) contained pus (yellow, thick drainage). Voiced sore throat and hoarse voice, requested to go to hospital, stated feeling ill all day. Physician notified and new orders send to hospital for evaluation and treatment. During an interview on 7/09/24 at 10:26 A.M., the physician's NP said he provided care for the resident the last several months. The resident is seen by the wound care specialist weekly. Neither he nor the physician had been notified of missed wound treatments or the missed ordered antibiotics. If wound treatments are missed, the wound care specialty team should be notified first, then the physician or NP. During an interview on 7/10/24 at 9:35 A.M., the Director of Nursing (DON) said the facility wound nurse completes wound rounds with the specialty provider weekly. She also completes all wound care treatments during the week. On the weekends, the Charge Nurses are responsible to complete the ordered treatments. All missed wound treatments should be reported to the wound care team, if seen by them or by the physician. If a resident is ordered to take an antibiotic for a wound, the resident should remain on the antibiotic until discontinued by the ID physician. There should be no missed treatments. The risk of untreated wounds could be infection, and further injury. If a resident refused treatments, then staff should notify the MD, and document in the record. During an interview on 7/11/24 at 7:29 A.M., the facility Wound Nurse said the facility staff had major issues completing wound care in May. She had been the facility wound nurse about two months. She works Tuesdays through Friday as the wound nurse. She works every other weekend as a floor nurse. When she completed audits, she observed multiple wound treatments had not been completed. The nurses should assess skin daily. The resident was on antibiotics for wounds from a hospital stay in June. The antibiotic was prescribed by the ID physician, it would have been very important for the resident to finish those. The staff documented in the physician order, that an NP stopped the ordered antibiotic, and it was stopped incorrectly. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/11/24 at 9:23 A.M., the specialty wound care NP said she expected staff to administer wound care orders and medications as written. If residents resist wound care, staff should re-approach and if the resident continued to refuse, staff should document. Blanks on the TAR indicate a treatment was not done. The physician, NP or herself should be told when treatments are not done. She has educated staff multiple times of the importance of completing wound treatments. Resident #72 is totally dependent on staff for care. She and the facility's wound care nurse frequently provided hygiene care due to the resident being heavily soiled. The resident was in the hospital in June for worsening of the sacral wound. The hospital ID (Infectious Disease) physician prescribed antibiotics for an extended time, the facility should have administered those as ordered. Antibiotics are important for wound healing. Santyl is used to clean out the dead tissue in a wound. If Santyl is not administered as ordered, the wound is not debrided and dead tissue remaining in the wound bed can contribute to infection beginning. During an interview on 7/17/24 at 3:16 P.M., the resident's physician said neither he nor the NPs were notified of missed wound care or questions regarding stopping the ID physician ordered antibiotics. The ID physician should have been contacted regarding stopping the ordered antibiotic. The resident is seen weekly by the wound care NP. The resident was sent to the hospital in June and received a surgical debridement of the sacral wound. The ID physician ordered the antibiotic and Flagyl for 6 weeks to treat various bacteria in the wound. MO00237027

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility failed to fully implement the restorative therapy program for residents with limited mobility. The facility failed to ensure appropriate services and assistance to maintain or improve mobility for three residents (Residents #88, #4 and #123). Resident #88's therapy was discontinued due to insurance and restorative services was not recommended. Resident #88 also had a hand contracture, with therapy recommendations for a hand splint that was not ordered. The sample was 30. The census was 151. Review of the facility's Restorative Nursing Program policy, dated 10/24/22, showed: -Purpose: The Restorative Nursing Program provides nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning; -Policy: A resident may be started on a Restorative Nursing Program: Upon admission to the Facility with restorative needs, but is not a candidate for formalized rehabilitation therapy; -When restorative needs arise during the course of a longer-term stay; -In conjunction with formalized rehabilitation therapy; When a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy; -The Director of Nursing Services (DNS), or their designee, manages and directs the Restorative Nursing Program. licensed rehabilitation professionals, (physical therapists, occupational therapists, and speech therapists} provide ongoing consultation and education for the Restorative Nursing Program; -General restorative nursing care is that which does not require the use of a qualified professional therapist to render such care. The basic restorative nursing categories include: -Active range of motion (AROM); -Passive range of motion (PROM); -Splinting or bracing; -Amputation/Prosthesis management; -Bladder training or bowel training; -Bed mobility; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Transfer training; -Dressing or grooming; -Walking; -Eating or swallowing; -Communication; -Procedure: Residents will be reviewed by the Interdisciplinary Team (IDT) upon admission, readmission quarterly, and as needed to identify any decline in activity of daily living (ADL) function. If a decline is identified, the IDT will evaluate whether the resident is an appropriate candidate for restorative services; -The Attending Physician, Licensed Nurse or Therapist may refer the resident to the rehabilitation department for rehabilitative screening; -The Licensed Therapist will document whether the resident may benefit from a more detailed rehabilitation evaluation or from unskilled therapy (restorative nursing services that can be provided by caregivers); -In conjunction with the Attending Physician and staff, therapists will propose a rehabilitation or restorative care plan that provides an appropriate intensity, frequency and duration of interventions to help achieve anticipated goals and expected outcomes; -If a potential to benefit from rehabilitation therapies (either skilled or unskilled) is identified, the Attending Physician will order a relevant therapy evaluation; -An order will be obtained from the Attending Physician as indicated for participation in the Restorative Nursing program or for skilled rehabilitation services (physical, occupational, or speech therapy). 1. Review of Resident #88's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/27/24, showed: -Mild cognitive impairment; -Diagnoses included coronary artery disease, high blood pressure, renal failure, hemiplegia (partial paralysis on one side), malnutrition, anxiety, depression, psychotic disorder; -Range of motion impairment to one side of the upper extremity; -Occupational therapy minutes: 0; -Physical therapy minutes: 0; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last seven calendar days: Range of motion (passive): 0; -Range of motion (active): 0; -Splint or brace assistance. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has an ADL self-care performance deficit related to impaired balance, limited mobility. Resident prefers to wear adult briefs at all times; -Goal: No decline in ADL functioning; -Interventions: Encourage out of bed daily; -Incontinent care as needed; -Skin assessment as needed; -Resident is total assist of one staff with his/her ADLs; wheelchair mobility when out of bed, dressing, bathing; -Extensive assistance of one with his/her meals, toileting, and bed mobility, non ambulatory; -Two person assist for transfer may use Hoyer (full mechanical lift) if needed. Review of the resident's Physician's Orders Sheet (POS), dated July 2024, showed: -An order, dated 5/2/24, clarification order: Patient will be seen for skilled Occupational Therapy (OT) five times per week (wk) for four weeks and may include therapeutic exercises, therapeutic activities, neuromuscular re-education, self-care training, wheelchair management, contracture management/orthotic scheduling, electrical stimulation (e-stim)/ultrasound modalities, and patient/caregiver education; -No physician's orders for hand splint. Observation and interview on 7/9/24, 7/11/24, 7/15/24, and 7/16/24, showed: -On 7/9/24 at 11:27 A.M., resident lay in bed with eyes closed. The resident's hands were contracted and no hand splint worn; -On 7/11/24 9:14 A.M., resident lay in bed. He/She said he/she had to be wheeled by staff because he/she cannot operate a wheelchair. He/She had a stroke and his/her left side was affected. He/She cannot use legs/feet to push him/herself in a wheelchair. He/She cannot use his/her hands to roll him/herself, staff have to push him/her. Staff talked to him/her about using a different wheelchair. The resident had not heard anything about it since. He/She had not received therapy or restorative. The resident wore no hand splint; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/15/24 8:15 AM, the resident was in his/her room, in bed. He/She received a meal. He/she ate with the right hand and used fingers to pick up food without the use of utensils. The resident's left hand was contracted. The resident wore no brace; -On 7/16/24 at 8:25 A.M., the resident was eating a meal, served on the bedside table. The resident ate the meal with his/her right hand and used fingers to pick up food without the use of utensils. The resident's left hand was contracted. The resident wore no hand splint. Review of the resident's OT evaluation, dated 4/25/24, showed: -Diagnoses: Hemiplegia and hemiparesis, contracture of muscle, muscle weakness, unspecified lack of coordination, need for assistance with personal care, contracture left elbow; -Frequency: Five times a week; -Duration: Four weeks; -Certification period: 4/25/24 through 5/23/24; -Reason for Referral Current Illness: Patient referred to OT due to exacerbation of decrease in functional mobility, decrease in range of motion (ROM), decrease in strength, decreased coordination, decreased neuro-motor control, decreased postural alignment, increased need for assistance from others, paralysis/paresis, reduced dynamic balance, reduced ADL participation, and wheelchair evaluation; -Functional Limitations Present due to Contracture: Yes; -Functional Limitations as Result of Contracture(s): Turning in bed, dressing; -Is skilled therapy needed to address impairment: Yes -Current Orthotic Device: To further assess and order/fabricate; -Location of Contracture: Left elbow, wrist and digits; -Orthotics: Splint/Orthotic recommendations: It is recommended the patient wear a resting hand splint and an elbow extension splint on left elbow and on left hand at all times except bathing and exercise in order to maintain joint integrity and inhibit abnormal positions; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clinical Impressions: Patient uses Hoyer lift to transfer. Patient was assessed for safe manual wheelchair mobility. Patient does not currently have a chair and utilizes facility chair. Patient requires ultra light-weight wheelchair due to facility chair not being suitable for patient due to poor positioning, endurance, difficulty with maneuvering. Patient will benefit from an adjustable axle to promote proper propulsion and positioning/postural alignment. Patient cannot use a walker or cane as patient is non-ambulatory. Patient requires manual wheelchair (MWC) to complete ADLs. Patient has asymmetrical posture with, left leaning thoracic, and flaccid left arm. Patient will require a half tray in order to manage flaccid left arm, prevent subluxation (partial dislocation) and improve positioning. Patient requires support to maintain sitting balance and midline. Patient is unable to perform self-repositioning and pressure relieving techniques in wheelchair due to inability to perform wheelchair pushups or stand. Patient will utilize device life-long in order to improve quality of life, and increase interaction with environment. Further skilled OT is indicated to address strength and coordination deficits to increase safety and participation in ADLs. Review of the resident's Occupational therapy discharge summary, showed: -Patient was seen for nine days during the 4/25/24 through 5/7/24 progress period; -Discharge destination: Long term care setting; -Discharge reason: Change in payer source; -Discharge recommendation: Home exercise program; -Restorative program established: Not indicated at this time; -Functional Maintenance program established: Not indicated at this time. During an interview on 7/11/24 at 9:39 A.M., therapy staff confirmed the resident had OT last year and this year, but he/she could not continue because the resident's insurance was out of state. During an interview on 7/15/24 at 2:53 P.M., Restorative Aide W said the resident is not on restorative therapy. The resident was on restorative therapy in the past when Restorative Aide W first started at the facility. The resident was on therapy too long and it was discontinued. The resident went back on Physical therapy (PT)/OT again, but he/she did not go back on restorative after the skilled therapy. 2. Review of Resident #4's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Functional range of motion limited to the upper and lower extremity; -Staff provide full care assistance; -Did not receive therapy services; -No restorative therapy received; (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included: Stroke, epilepsy, left sided paralysis, abnormal posture, need for assistance with personal care and dementia. Review of the care plan, in use during the survey, showed: -Focus: Limited physical mobility and requires assistance with transfers due to stroke and left sided weakness; -Goal: Maintain current level of mobility to self propel in his/her wheelchair; -Interventions: Two staff for transfers, invite to activity programs, encourage physical activity and group exercises. Refer to PT/OT as needed. Review of the occupational and physical therapy discharge summary, dated 5/2/24, showed: -Discharge recommendations: The resident is a resident of the facility with 24 hour supervision; -Restorative program: Restorative program established/trained, not indicated at this time; -Functional maintenance: Functional maintenance program established/trained: not indicated at this time. During an interview on 7/8/24 at 2:23 P.M., the resident said he/she does not get any therapy services. He/She had a stroke and a contracted right hand, his/her movement can be difficult. Staff provide full care. 3. Review of Resident #123's quarterly MDS, dated [DATE], showed: -Rarely understood; -Used wheelchair for mobility; -Staff provide maximal assistance for toileting, dressing, hygiene and mobility; -Received no physical, occupational or restorative therapy; -Diagnoses included quadriplegia (paralysis from the neck down), lack of coordination and dementia. Review of the care plan, in use at the time of the survey, showed: -Focus: Self-care deficit; -Goal: Maintain current level of function; -Interventions: Needs extensive assistance with personal hygiene, grooming, bathing, dressing and assistance of one staff required for eating. Review of the occupational and physical therapy discharge summary, dated 5/2/24, showed: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Discharge recommendations: The resident is a resident of the facility with 24 hour supervision; -Restorative program: restorative program established/trained, not indicated at this time; -Functional maintenance: functional maintenance program established/trained: Not indicated at this time. Observation on 7/8/24 at 12:55 P.M., showed the resident awake in his/her chair with contractures to the hands and both upper arms. Review of the physician's orders sheet on 7/10/24 at 4:15 P.M., showed no orders for restorative therapy. 4. During an interview on 7/15/24 at 2:53 P.M., Restorative Aide W said he/she was pulled to the floor every day to work as a Certified Nurse's Aide (CNA). They do not have enough aides. If it is the first through the tenth of the month, he/she is not pulled to work as a CNA because he/she is responsible for vitals and weights for the entire facility. After the tenth, he/she is pulled as a CNA. They need five aides total, that also includes one for showers, and then he/she would be able to focus on restorative. If a resident refuses restorative three times in a row, he/she will let therapy know. During an interview on 7/15/24 at 9:37 A.M., OT UU said Resident #88 had out of state insurance and his/her OT was discontinued. The business office would know if the resident's insurance had changed. OT UU thought restorative therapy was recommended. It is documented on the form not indicated, but it a computer issue. It chooses that. Sometimes, the resident participated in therapy, and sometimes he/she did not. Therapy was getting ready to discharge him/her anyway. The restorative aide is pulled a lot. Some of the aides on the floor could do some exercises with the resident. OT UU was asked if doing the exercises with staff in home exercise therapy would be appropriate for restorative therapy. OT UU said Home exercise program as indicated on the record, meant there were exercises the resident could do alone. The resident was shown the exercises as well. OT UU did not know if the resident was ever ordered a hand splint. The resident had been on and off therapy a few times. Therapy would be responsible for ordering the hand splint and nursing would make sure it was on the POS. Therapy would show the resident how to put it on, then it was nursing's responsibility. OT UU did not know if the option for restorative had been revisited for the resident. Resident #123 is mobile, and OT UU did not recall the resident having a stroke, but he/she had severe dementia. Resident #4 refused and did not like anyone touching his/her hand. He/She had been assessed for a new wheelchair, but OT UU did not know what type of wheelchair. OT UU said he/she did not know of any residents currently on a restorative program. During interviews on 7/12/24 at 9:33 A.M. and on 7/16/24 at 11:18 A.M., the Administrator said there isn't a restorative program right now. They are working on it. The restorative aide is pulled to the floor a couple of times a week. They are trying to attain a program. She did not remember when the last time the facility had a restorative program. In the past 90 days there has not been anything in the program. There is a feeding program. If a resident was not on restorative, they could have some therapy if Medicare Part B services were available. Therapy had not recently recommended any resident to be on the program. She would expect there to be orders for a splint, and expected aides to apply the splint. Therapy will also provide education to the aides on the floor to make sure they know what to do if there is an order for restorative. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37672

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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 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. 46888 Based on observation, interview and record review, the facility failed to ensure one resident's room was free from hazardous chemicals at the bedside (Resident #124). The sample was 30. The census was 151. Review of the Material Safety Data Sheet (MSDS) for Odoban (disinfectant cleaner), dated 2/10/2022, showed: -Regulatory information: immediate health hazard; -Hazard statement: may cause respiratory irritation. Causes serious eye irritation. Review of the MSDS for Raid Ant and Roach Killer, dated 9/6/2016, showed: -Precautions for safe handling: avoid contact with skin, eyes and clothing, do not enter places where used or stored until adequately ventilated, flammable. Review of the MSDS for Febreeze Air Effects, dated 2/24/2014, showed: -Advice on safe handling: use personal protective equipment as required. Keep container closed when not in use. Review of Resident #124's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/5/24 showed the following: -Diagnoses of schizoaffective disorder (combination of schizophrenia and mood disorder symptoms), dementia and major depressive disorder; -Resident is ambulatory and has full function of his/her arms; -Moderately impaired cognition. Observation on 7/8/24 at 9:07 A.M., showed the resident's nightstand had one can of Raid bug spray half full, two full cans of Odoban odor spray, and two full spray bottles of Febreeze odor spray. Observation on 7/9/24 at 7:27 A.M., showed the top of the resident's nightstand had one can of Raid bug spray half full, two full cans of Odoban odor spray, and two full spray bottles of Febreeze odor spray. Observation on 7/10/24 at 6:58 A.M., showed the top of the resident's nightstand had one can of Raid bug spray half full, two full cans of Odoban odor spray, and two full spray bottles of Febreeze odor spray. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/11/24 at 7:13 A.M., showed the top of the resident's nightstand had one can of Raid bug spray half full, two full cans of Odoban odor spray, and two full spray bottles of Febreeze odor spray. During an interview on 7/15/24 at 2:38 P.M., Certified Nursing Assistant (CNA) M said all staff are expected to observe residents' belongings to ensure resident does not have harmful chemicals. He/She said chemicals have a potential to be harmful to the resident. During an interview on 7/15/24 at 2:47 P.M., Licensed Practical Nurse (LPN) L said all staff should check resident rooms for chemicals. He/She said resident rooms are expected to be free from chemicals. During an interview on 7/16/24 at 11:44 A.M., the Administrator said she expected residents' rooms to be free from chemicals. She expected all staff to observe residents' rooms for harmful chemicals.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37672 40290 Based on observation, interview, and record review, the facility failed to identify one resident's significant weight loss of -24.93% in a timely manner, resulting in delayed identification of interventions to support the resident's nutritional status (Resident #127). The facility failed to ensure three residents with significant weight loss were provided with therapeutic diets, supplemental food items, alternative food items, and/or feeding assistance to address weight loss (Residents #127, #123, and #50). The sample was 30. The census was 151. Review of the facility's Nutrition/Hydration Management policy, revised 10/24/22, showed: -Purpose: To ensure that each resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible based on the resident's comprehensive assessment. To ensure that a resident receives a therapeutic diet when there is a nutritional problem; -Policy: -The concept of nutrition management is an interdisciplinary process. The key components of this system are: -a. Maintaining nutritional status as indicated by clinical measures such as body weight, biochemical measure, and hydration; -b. Developing an individual nutrition/hydration program based on individual assessed needs; -c. Implementing the nutrition/hydration program; -d. Identifying new instances of unplanned weight loss or gain; and -e. Ongoing assessment, monitoring, and evaluation of the effectiveness of the nutrition/hydration management program; -The goal of any nutrition/hydration management process is to improve quality of life. The goal of the interdisciplinary team is to promptly identify a resident with nutrition/hydration at risk factors and develop and effective management program; -Procedure included: -A comprehensive care plan is developed by the interdisciplinary team that addresses nutrition/hydration and an individualized nutrition/hydration management program based on individualized assessed need; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The nutrition/hydration management program may address the following; -The factors contributing to actual or potential causes for inadequate nutrition or hydration status; -Specific modification in the resident's meal plan including food from outside the facility and/or special food activities; -Pertinent socialization and recreation factors; -Dining locations and the type and level of dining assistance required; and -Position, cueing/assistance, and adaptive equipment needed. Review of the facility's Therapeutic Diets policy, revised 10/24/22, showed: -Purpose: To ensure that the facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders; -Policy: Therapeutic diets are diets that deviate from the regular diet and require a physician order. Per the physician order, therapeutic diets are planned, prepared and served in consultation with the Dietitian; -Procedure: -The nursing staff is responsible for communicating the physician's order for a therapeutic diet to the dietary department in writing; -The therapeutic diet will be reflected on the resident's tray card. -The Dietary Manager will periodically review the resident's tray card and the physician's dietary orders to ensure that the information is consistent. 1. Review of Resident #127's medical record, showed: -admitted [DATE]; -Diagnoses included malnutrition, abnormal weight loss, dysphagia (difficulty swallowing), cognitive communication deficit, depression, anxiety, hallucinations, diabetes, heart failure, high blood pressure, kidney failure, and muscle wasting and atrophy. Review of the resident's electronic physician order sheet (ePOS), showed: -An order, dated 9/1/23, for Remeron (antidepressant) Sol Tab oral disintegrating tablet, 15 milligrams (mg.), one tablet by mouth at bedtime for depression; -An order, dated 9/26/23 through 1/12/24 for health shake three times daily with meals for weight loss; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 9/26/23 through 1/15/24 for Ensure (nutritional supplement) oral liquid, one can by mouth three times a day for supplement. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/4/23, showed: -Moderate cognitive impairment; -Supervision or touching assistance required for eating. Review of the resident's medical record, showed: -On 12/5/23, weighed 181.4 pounds (lbs.); -A physician order, dated 12/30/23, for ice cream with meals; -On 1/5/24, weighed 169.8 lbs; -The resident had a significant weight loss of -6.39% between 12/5/23 and 1/5/24. Review of the resident's physician progress note, dated 1/8/24, showed the resident eating poorly, refusing to drink Ensure sometimes. Staff informed patient likes food from outside, home food. Family brings food sometimes. Review of the resident's ePOS, showed an order, dated 1/24/24, for megestrol acetate (medication used to treat loss of appetite) oral tablet 20 mg., give 40 mg. orally one time a day for appetite stimulant. Review of the resident's physician progress note, dated 2/5/24, showed resident eating very poorly. Staff informed patient likes food from outside, home food. Family brings food sometimes. Patient lost 10 lbs. in 30 days. Continue Remeron, Megestrol, Ensure. Talked to patient's family, he/she wants gastrointestinal (GI) tube (a tube surgically inserted into the stomach to provide hydration, nutrition, and medications). Will consult GI. Review of the resident's weights, showed on 2/6/24, the resident weighed 170.2 lbs. Review of the resident's physician progress note, dated 3/4/24, showed resident continuing to refuse his/her foods. Staff informed he/she only eats food from outside of the facility when his/her family brings it. Watched him/her during lunch, did not take a single bite. Eating very poorly, limited activity. Continue Remeron, Megestrol. Facility trying to contact a GI. Review of the resident's weights, showed on 3/5/24, the resident weighed 169.6 lbs. Review of the resident's physician progress note, dated 3/26/24, showed talked to resident about his/her family's recommendation for GI tube as he/she is not eating or drinking. Resident said no GI tube. Eating very poorly, very limited activity. Continue Remeron, Megestrol. Facility trying to contact GI. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's ePOS, showed an order, dated 3/28/24, for Ensure with meals (scheduled to be administered at 7:00 A.M., 12:30 P.M., and 5:30 P.M.). Review of the resident's weights, showed on 4/5/24, he/she weighed 171.2 lbs. Review of the resident's physician progress notes, showed: -On 4/8/24, the physician documented the resident's family called to inform he/she no longer wants to put in the GI tube. Family will bring food more often so resident will eat. Resident does not eat food from facility. Continue Remeron, Megestrol, Ensure. Family does not want GI tube anymore. Family will bring food from outside as resident only eats that. Resident does not drink Ensure; -On 5/6/24, the physician documented the resident with low appetite. Does not eat food from facility. Continue Remeron, Megestrol, Ensure. Consult Registered Dietician (RD). Review of the resident's weights, showed on 5/7/24, he/she weighed 172.5 lbs. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -No behaviors exhibited; -Independent with eating; -Weight: 173 lbs. Review of the resident's quarterly dietary profile, signed by the Dietary Manager (DM), dated 5/22/24, showed: -Percentage intake: 100%; -Current nutritional supplement: Ensure; -Appetite: Good; -Likes: Turkey with dressing, burger with cheese, tenders. Dislikes: Broccoli. Review of the resident's weights, showed: -On 6/3/24, weighed 170.5 lbs.; -On 6/5/24, weighed 129.5 lbs. -The resident had a significant weight loss of -24.93% between 6/3/24 and 6/5/24. Review of the resident's speech therapy evaluation, dated 6/4/24, showed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Reason for referral/current illness: Dysphagia due to decline in oral/pharyngeal (related to the pharynx, the conductive structure located in the midline of the neck) function, risk for weight loss, safety awareness, weight loss, and signs/symptoms of dysphagia; -Recommendations: Mechanical soft texture, thin liquids. Occasional supervision. Review of the resident's ePOS, showed an order, dated 6/4/24, for regular diet, mechanical soft texture. Review of the resident's medical record, showed: -On 6/7/24, the nurse documented the resident observed chewing fish during meal time, then proceeded to spit chewed fish into a small plastic bag. Resident asked about behavior and stated, I don't know what I'm doing. I won't do it again. RD notified; -On 6/7/24, the RD documented significant weight loss triggering -41 lbs. in two days. Talked to nursing and current weight appears correct. 41 lb. weight loss not possible so questioning the weights before 6/5/24 at this point. Resident receiving regular, mechanical soft with ice cream and Ensure with meals. Resident needs supervision and encouragement. Per nursing, resident chewed up fish and then did not eat it today. Now working with speech therapy. Resident is a picky eater and sometimes refusal of supplementation noted. Receiving Megestrol and Remeron, both have potential for appetite stimulation; -On 6/9/24, the nurse documented the resident observed during meal consumption this morning. Resident observed placing full spoon of oatmeal in mouth, chews it, and spits it back onto spoon. Resident places chewed oatmeal onto plate, separates it from what has not been chewed. Resident asked if there were any issues swallowing. Resident stated, I don't know. Resident provided chocolate Ensure and tolerated Ensure well without issues; -On 6/13/24, the nurse documented the resident provided with Ensure this morning, poor meal consumption, less than 25%. Nurse continues to encourage and educate resident; -Staff documented Ensure, Remeron, and Megestrol as administered per physician order on the June 2024 medication administration record (MAR). Review of the resident's care plan, in use at the time of survey and reviewed 7/8/24, showed: -Focus: Resident has an activities of daily living (ADL) self-care performance deficit; -Interventions included: resident needs limited assistance of one for eating; -Focus: Resident has nutritional problem or potential nutritional problem related to diet restrictions; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Interventions included: Due to resident declining to consume his/her Ensure, order discontinued. Monitor weight as directed. Provide and serve diet as ordered, regular diet, mechanical soft texture, regular consistency. Provide and serve supplements as ordered: ice cream with meals. Staff reports of family with outside foods and he/she consumes with no complaints, encourage resident choose food from dietary that he/she enjoys, offer him/her snacks of his/her choice throughout the day and evenings. Weight at same time of day and record, resident is weighed during the day with the use of his/her wheelchair; -The care plan failed to identify the resident's poor intake of food served at the facility, increased intake of meals eaten with family, and his/her behavior of chewing food and spitting it out, and to identify interventions to address the behavior. Review of the resident's diet card, undated, showed Regular diet checked at the top of the card. No documentation of physician-ordered supplemental ice cream or Ensure. Likes and dislikes not documented. Observation on 7/8/24 at 10:28 A.M., showed the resident seated in a wheelchair. The resident appeared thin with pronounced collar bones and jaw bones. During an interview, the resident exhibited some confusion. He/She said he/she ate breakfast. He/She was unable to answer questions when asked about his/her meal intake and weight loss. Observation of lunch on 7/8/24 at 11:57 A.M., showed the resident sat at a table in the dining room. Staff served the resident mechanical soft Salisbury steak, mashed potatoes with gravy, a scoop of vegetables, and a carton of Ensure. No ice cream served to the resident. The resident consumed less than 25% of each food item and pushed his/her food around the plate. Staff provided the resident with two meat and cheese sandwiches. The resident took bites of one sandwich and spit the food onto his/her plate. Licensed Practical Nurse (LPN) D approached the resident and asked if he/she was spitting his/her food out and the resident said no. LPN D walked away, and the resident continued to take bites of the sandwich and spit it back onto the plate. At 12:21 P.M., LPN removed the resident's plate and encouraged him/her to drink the Ensure. At 12:29 P.M., the resident finished the Ensure. Observation on 7/8/24 at 4:54 P.M., showed the resident on his/her left side in bed with a plate of whole egg rolls and noodles. No ice cream served to the resident. No Ensure observed. No staff in the resident's room to supervise or provide encouragement. The resident used his/her hands to rip up the food and put it in his/her mouth, spitting bits of food out of his/her mouth while he/she chewed. Observation of lunch on 7/9/24 at 12:07 P.M., showed the resident sat in the dining room. Staff served the resident a chopped-up meat patty, mashed potatoes with gravy, mixed vegetables, a cup of ice cream, and a carton of Ensure. The resident took bites of his/her food and spit it back onto the plate. Staff did not offer alternatives or encourage the resident during the meal. At 12:26 P.M., staff removed the resident's plate. In total, the resident consumed the entire cup of ice cream, approximately 30% of the meat, and a couple bites of vegetables. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Observation of lunch on 7/12/24 at 11:43 A.M., showed the resident sat in the dining room. Staff served the resident a mechanical soft fish patty, spaghetti, sliced carrots, and a piece of cake. No ice cream served to the resident. No Ensure observed. The resident pushed the food around on his/her plate. Staff provided the resident with two meat and cheese sandwiches. The resident consumed some of both sandwiches, spitting the remainders of the sandwiches onto his/her plate. In total, the resident consumed just over one whole sandwich. Observation on 7/15/24 at 11:44 A.M., showed the resident sat in the dining room with a whole hamburger and crinkle-cut fries. No ice cream served to the resident. No Ensure observed. The resident used his/her hands to rip up the hamburger and put it in his/her mouth, spitting bits of food out while he/she chewed. Observation on 7/15/24 at 7:06 A.M., showed Certified Nurse Aide (CNA) E brought the resident to the shower room by the elevators on the first floor to have him/her weighed. CNA/Restorative Aide (RA) W entered the shower room and said he/she would leave the resident in his/her wheelchair and put him/her on the scale to obtain the weight. CNA E said no, he/she needed to get the wheelchair weight first. CNA E transferred the resident out of his/her wheelchair into a regular chair, then weighed the wheelchair on the scale. The wheelchair weighed 34.4 lbs. CNA E transferred the resident back to his/her wheelchair and positioned him/her on the scale. The scale showed 164.6 lbs. After subtracting the wheelchair weight, the resident's weight was determined to be 130.2 lbs. During an interview on 7/15/24 at approximately 7:10 P.M., CNA E said CNA/RA W has been obtaining the weights for all residents in the facility. The weights were not obtained properly. Minutes ago, RA W wanted to weigh the resident in his/her wheelchair and that is not correct. The resident has visibly lost a lot of weight over the past few months. CNA E has talked to the resident's doctor and psychiatrist about the weight loss. Someone recommended a GI tube, but the resident or his/her family said no. A month ago, the resident began spitting out his/her food. The resident loves snacks, such as oatmeal pies and chocolate bars. He/She is supposed to be getting ice cream from dietary, but hasn't been. During an interview on 7/15/24 at 11:28 A.M., CNA/RA W said he/she was he/she is responsible for obtaining weights on the residents in the facility at the beginning of each month. The facility has two stationary scales on the first floor, and a chair scale that CNA/RA W can bring to the other floors of the facility. He/She uses different scales every time he/she weighs different residents. Whichever scale he/she uses changes by resident or day, depending on what is closer at the time he/she obtains a resident's weight. He/She saw Resident #127 losing weight and getting smaller over the past few months, but the numbers on the scale stayed the same, so he/she went with that. Recently, he/she realized the chair scale wasn't calibrated, and he/she doesn't know how to calibrate it, so he/she told the MDS Coordinator. During an interview on 7/15/24 at 2:48 P.M., CNA R said the resident used to be bigger and has lost a lot of weight since admission. He/She used to receive a mechanical diet. They switched his/her diet to regular last month and that's when he/she started spitting out his/her food. He/She eats well when his/her family comes to visit. His/Her average meal intake is about 50%. He/She is supposed to get ice cream at all meals, but dietary only gives out ice cream on certain days. The Certified Medication Technicians (CMTs) give the resident Ensure. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/16/24 at 7:11 A.M., CNA EE said the resident has lost a lot of weight. For a while now, he/she has been chewing up his/her food and spitting it out. He/She doesn't like the food served at the facility. He/She needs to be served new foods instead of the same foods served over and over at the facility. When he/she doesn't eat, staff should offer him/her something else. The problem is that dietary staff don't send the right food texture or the right food items. When nursing calls down to the kitchen to ask for the right items or request something different, dietary staff gets mad. The only food they will send up as an alternative is a cold cut sandwich. During an interview on 7/15/24 at 12:32 P.M., the Social Services Director (SSD) said the resident has dementia and has good and bad days. Sometimes the resident eats and sometimes he/she spits out his/her food. His/Her meal intake depends on who is there as well. He/She can eat a bunch when with family and eats well with them. He/She prefers food from outside of the facility. The SSD was not aware the resident had a significant weight loss. Weight loss is a topic discussed in the weekly interdisciplinary (IDT) meetings. She recalled them discussing the resident's weight loss before and people mentioned getting the resident more shakes. During an interview on 7/16/24 at 9:30 A.M., the DM said the resident has been chewing his/her food and spitting it out. He/She eats well when his/her family comes to visit. He/She is supposed to receive a mechanical diet, not a regular diet. During the interview, the DM reviewed the resident's diet card, which showed regular diet. The DM said the resident's diet card had been changed by someone else, and he did not know who. Dietary staff should not change the diet cards and should always go by physician-ordered diet. The DM saw the resident when he/she was first admitted to the facility and the resident has visibly lost weight since then, and he/she is thin. The resident's weight has gone south and the DM does not know why. The resident eats well when his/her family comes to visit. The DM attends the IDT meetings, which are held weekly. The resident's weight loss was discussed during an IDT meeting one time and has not been mentioned since then. During an interview on 7/16/24 at 11:09 A.M., the Speech Therapist (ST) said the resident was referred to her for an evaluation in June 2024, and she completed a swallow evaluation. The resident has been having issues with swallowing. He/She has been expelling his/her food, but not always. His/Her diet was downgraded to mechanical soft because he/she does not have enough teeth. She expects the resident to receive a mechanical soft diet. If dietary serves the resident whole foods, nursing staff usually chop up the food for the resident. The resident has been spitting out his/her food, which is a fairly new behavior. If the food is something the resident likes, he/she will eat it. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/16/24 at 10:20 A.M., the MDS Coordinator said residents are weighed monthly by CNA/RA W. If there is a discrepancy, the resident may be moved to weekly weights. She does not know how Resident #127's significant weight loss was missed. Maybe staff was using a different wheelchair to weigh the resident. Maybe the resident was weighed using the chair scale, which was messing up a lot on people. When the weight loss was noted, she had the resident re-weighed to verify the weight was correct, and it was. The scales in the facility were recalibrated. When staff saw the resident was losing weight, but the numbers on the scale stayed the same, she would think staff should report it to the nurse. The resident doesn't always drink his/her Ensure and some CNAs have to take the time to sit with him/her and coax him/her to drink it. His/Her family can get the resident to eat. The MDS Coordinator was not aware of the resident's spitting out food while eating. She expects the resident to receive a mechanical soft diet as ordered. If the resident requests a regular texture diet, she expects nursing staff to let the ST know so she can evaluate the resident. If the resident was not eating, she expected staff to offer different types of foods and to get him/her something he/she wants. She expected the resident to be served ice cream at meals, per physician order. She attends the weekly IDT meetings. She does not recall discussing the resident's weight loss in the IDT meetings. 2. Review of Resident #123's medical record, showed: -Rarely understood; -Staff provide maximum assistance for toileting, dressing, hygiene and eating; -Diagnoses included: quadriplegia (paralysis of all four limbs), mild protein calorie malnutrition, dysphagia, muscle weakness, and abnormal weight loss. Review of the care plan, in use during the survey, showed: -Focus: The resident has a diagnosis of adult failure to thrive due to decline in health; -Goal: The resident will have needs met by staff; -Interventions: Staff will assist the resident to consume food and fluids; -Focus: The resident is at risk for dehydration related to memory impairment, decline in condition and poor fluid intake; -Goal: The resident will be adequately hydrated; -Interventions: Assess the need for fluids during rounds and meal times, Keep fluids at the bedside and staff assist with fluid consumption; -Focus: Nutritional problem; -Goal: Maintain adequate nutritional status as evidenced weight gain; -Interventions: Serve diet as ordered, provide and serve supplements as ordered, staff encourage fluids, weigh at the same time of day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the current ePOS, showed a diet order: Regular diet, pureed texture, upon request mechanical soft diet with assistance from restorative therapy aide. Review of the resident's monthly weights, showed: -February 2024: 91.2 lbs. -March 2024: 87.0 lbs. Review of the ePOS, showed an order, dated 3/18/24 for Ready Care (nutritional supplement) 120 milliliters (ml), three times a day. Review of the monthly weights, showed: -April 2024: 82.5 lbs; -May 2024: 80.0 lbs. Review of the resident's dietary notes, showed: -On 5/6/24 at 1:58 P.M., the resident continued on a pureed diet. He/She receives shakes three times a day, Ready Care 2.0 at 120 ml three times a day, Juven (protein supplement) and liquid protein 30 ml as supplement. The resident assisted by staff at meal times, intake fair at times. Current weight 80 lbs., reflecting a 3.1% loss in 30 days and 12.3% in 90 days. Increased calorie and protein needs secondary to malnutrition, weight loss and low body mass index (BMI, a measure of body fat based on height and weight). Speak with physician and family regarding non-oral nutrition; -On 5/7/24 11:27 A.M., addendum to review note on 4/6/24: Discussed with IDT regarding recommendations. The resident's family declined both tube feeding and hospice services. Recommend discontinue shakes and replace with Ready Care 120 mls three times a day with meals in addition to currently ordered Ready Care. Review of the ePOS, showed an order, dated 5/8/24, for Ready care 2.0 ml, give 120 ml, three times a day. Review of the May 2024 MAR, showed: -An order, dated 3/18/24, for Ready care 2.0, 120 ml three times a day. Scheduled daily at 9:00 A.M., 1:00 P. M., and 5:00 P.M. Staff documented administered daily all times; -An order, dated 5/8/24, for Ready care 2.0, 120 ml three times a day. Scheduled daily at 9:00 A.M., 1:00 P. M., and 5:00 P.M. Staff documented administered daily all times. Review of the resident's June 2024 monthly weights, showed: 82.3 lbs.; Review of the June 2024 MAR, showed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-An order, dated 3/18/24, for Ready care 2.0, 120 ml three times a day. Scheduled daily at 9:00 A.M., 1:00 P. M., and 5:00 P.M. Staff documented administered daily all times; -An order, dated 5/8/24, for Ready care 2.0, 120 ml three times a day. Scheduled daily at 9:00 A.M., 1:00 P. M., and 5:00 P.M. Staff documented administered daily all times. Review of the dietary note, dated 6/7/24 at 11:23 A.M., showed weight on 6/3/24: 82.3 lbs BMI 15.1 underweight. Significant weight loss -8.9 lbs. Noted weight has remained overall stable since 3/28/24. Receiving puree diet order, may have a mechanical soft diet with restorative aide. Receiving Ready Care 120 ml three times a day, new order given on 5/8/24 for additional ready care 120 ml three times a day with meals. Resident's family declined tube feeding support and hospice services. Multiple interventions in place for nutrition support. Stability guarded with multiple comorbidities and disease progression. Observations on 7/8/24, showed: -At 10:41 A.M., the resident asleep in his/her chair. He/She appeared thin; -At 12:04 P.M., noted in the main dining room, at the assisted dining room table. CNA ZZ mixed all food together to feed the resident. Used a spoon, and the resident took two bites of food. CNA ZZ left the table to assist staff. At 12:19 P.M., CNA ZZ returned to the table, offered the resident another spoonful of food. The resident spat out the food. CNA ZZ cleaned the resident's face and pushed the resident toward the nurses station. No supplements were offered at the meal. CNA ZZ did not offer a warm meal or alternative to the resident. Observation on 7/9/24 at 7:58 A.M., showed the resident in his/her chair at the nurse's station. Staff offered and assisted the resident to drink Ensure. The resident consumed 50% of the container. Review of the resident's July 2024 monthly weight, showed the resident weighed 84.6 lbs. Observation on 7/15/24 at 8:50 A.M., showed the resident awake on the edge of the bed. The breakfast plate sat on the table next to the door, away from the resident. The plate contained uneaten eggs and meat. CNA/RA W said he/she and another CNA were the only aides on the floor at the time. He/She had not fed the resident but a bite or two, because other residents needed help. The resident is thin. No supplements were provided on the tray. CNA/RA W did not know where to get the supplements or if the resident was ordered supplements. During an observation and interview on 7/16/24 at 8:43 A.M., CNA/RA W weighed the resident. CNA/RA W placed the resident, who was seated in his/her wheelchair, onto the shower room scale. The weight was 173. 8 lbs in his/her chair. RA W said the chair weighs 94.8 lbs. The resident's current weight was 79 lbs. The resident had lost an additional 5.6 lbs. since the beginning of the month. He/She weighs all the residents at the beginning of the month and documents in the medical records. The resident had lost weight. He/She had observed staff give the resident a bite or two, then leave to provide care to another resident, and do not return to assist Resident #123 to finish eating. Observation on 7/16/24 at 7:55 A.M., showed the resident in the dining room at the assisted table. He/She was served a pureed breakfast plate at 7:58 A.M. RA W fed the resident. No supplement noted with the breakfast meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 7/16/24 at 9:35 A.M., the DM said the resident's meal ticket showed a pureed diet and 2.0 supplement. He and the kitchen staff do not put supplements on the meal trays. Nursing was responsible to provide all nutritional supplements. Resident #123 required staff assistance to eat. Staff should obtain the supplement from the medication room. Residents with weight loss should be discussed in the daily stand-up rounds. He was not aware Resident #123 experienced significant weight loss. He ordered supplements and if nursing staff do not have supplements or have low supply, he should be notified, and would order more. 3. Review of Resident #50's medical record, showed: -Diagnoses included malnutrition, nutritional deficiency, diabetes, anemia, high blood pressure, depression, bipolar disorder (mood disorder), and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves); -A physician order, dated 11/1/22, for regular diet, regular texture, regular consistency. Directions: Boost (nutritional supplement) twice daily between meals. Review of the resident's medication and treatment administration records, showed no order for Boost. Review of the resident's quarterly dietary profile, signed by the DM, dated 1/11/24, showed: -Appetite: Good; -Likes: Finger food, cheese sandwiches. Dislikes: Pork loin. Review of the resident's weights, showed: -On 3/8/24, weighed 163.6 lbs.; -On 4/5/24, weighed 150.0 lbs.; -The resident had a significant weight loss of -8.31% between 3/8/24 and 4/5/24; -On 5/3/24, weighed 147.0 lbs. -The resident had a significant weigh loss of -10.15% between 3/8/24 and 5/4/24. Review of the resident's RD note, dated 5/7/24, showed 9.9% weight loss in 90 days. Regular diet, Boost in between meals. Intake records indicate 25-100% consumed. No change warranted. Review of the resident's weights, showed on 6/3/24, the resident weighed 149.5 lbs. Review of the resident's RD note, dated 6/7/24, showed significant weight loss, 8.6% in three months. Overall stable for two months. Regular diet with Boost twice daily. Review of the resident's quarterly MDS, dated [DATE], showed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Cognitively intact; -No behaviors exhibited; -Independent with eating; -No weight loss. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Residents needs supervision with his/her ADLs; -Interventions: Resident is supervised with his/her ADLs: Eating; -Focus: Resident has nutritional problem or potential nutritional problem related to no teeth; -Goal: Resident will maintain adequate nutritional status as evidenced by maintaining weight within baseline, no signs/symptoms of malnutrition, and consuming at least 50% of at least three mails daily through review date; -Interventions included: Provide and serve diet as ordered, regular diet, regular texture, regular consistency. Provide and serve supplements as ordered, Boost twice daily between meals. Weigh at same time of day and record, resident is weighed during the day at the standing scale; -The care plan failed to identify the resident's significant weight loss. Review of the resident's diet card, undated, showed a regular diet. Staff did not document the Boost or [TRUNCATED]

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 Based on observation, interview and record review, the facility to failed to provide appropriate administration of enteral (passing through the intestine) nutrition for a resident who was dependent upon a gastrotomy tube (g-tube, a tube inserted through the belly that brings nutrition directly to the stomach) (Resident #22). Resident #22's physician's orders showed 40 milliliters (ml)/hour (hr) via g-tube continuously and water flushes 175 ml every four hours. On [DATE], the tube feeding machine was not set in the English language and infused at a rate of 140 ml/hour. Staff failed to ensure the g-tube machine settings were accurately set at 40 ml/hour during medication and treatment administrations and failed to report its language settings to management. The resident received approximately 400 cubic centimeters (cc) of feeding between 7:56 A.M. to 10:46 A.M., causing the resident to experience severe vomiting and he/she was transported to the hospital. The facility also failed to ensure g-tube site treatments were completed as ordered for one resident (Resident #45). The facility also failed to ensure staff completed a self-administration medication assessment and physician's orders to self administer medications via g-tube. The facility identified three residents dependent on a gastrotomy tubes. The census was 151. The administrator was notified on [DATE] at 2:56 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's Feeding Tube-Site Care policy, dated [DATE], showed: -Purpose: To inspect and prevent skin breakdown and complications for resident's with feeding tubes; -Policy: Site care will be provided twice daily until healed in the post-operative period following the feeding tube insertion; -The site of a well-established enteral feeding tube will be inspected daily for signs and symptoms of irritation, gastric leakage, or infection; -Procedure: Explain the procedure to the resident; -Wash hands. -Don (put on) gloves; -Remove old gauze if present; -Inspect the site for irritation, drainage or leakage; -Using a washcloth, gently clean around the site with warm water and mild soap; -Rinse the area with water and dry well; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Place a gauze drainage sponge around the site if needed for irritation, drainage, or leakage; -A smear of blood or a bit of clear yellow drainage is normal following post-operative insertion. Notify the Attending Physician if drainage has increased, is cloudy, yellow or green, has a foul odor, or if the skin surrounding the site is irritated. Review of the facility's Physician's Orders policy, dated [DATE], showed: -Policy: The Medical Records Department will verify that physician orders are complete, accurate and clarified as necessary; -Medication orders will include the following: -Name of the medication; -Dosage; -Frequency; -Duration of order; -The route and the condition/diagnosis for which the medication is ordered, if applicable; -Treatment orders will include the following: A description of the treatment, including the treatment site, if applicable; -The frequency of treatment and duration of order (when appropriate); -The condition/diagnosis for which the treatment is ordered; -Other orders will include a description complete enough to ensure clarity of the physician's plan of care; -Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline; -Supplies/medications required to carry out the physician order will be ordered; -Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the Medication Administration Record (MAR)/Treatment Administration Record (TAR) binders. Review of the facility's Medication-Self Administration policy, [DATE], showed: (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Policy: Residents who request to perform medication self administration will be assessed for capability. The assessment of medication self administration will ensure a clinically appropriate, effective process for the resident to provide self care. The Facility is responsible to ensure medications are administered as ordered by the Attending Physician even when self administered; -Procedure: During the admission process, residents will be asked if they wish to self administer medications; -Those residents who wish to self administer medications will be assessed during the admission process to ensure they have the necessary knowledge and skill(s) to safely self administer medications; -Additional assessments will be completed at least quarterly based on OBRA timeframes; -A referral for physical therapy/occupational therapy may be necessary to assess the resident for the necessary eye hand coordination and cognitive skills for medication self administration; -Based on clinical judgment, a Licensed Nurse may reassess a resident related to the safe self administration of medications as needed; -The resident must be able to demonstrate the following -Knowledge of medications and medication schedule; -The ability to read the medication label and manufacturer's insert; -Self-administration techniques including use of packaging, reading label, opening containers; -Ability to administer medication properly, e.g., insulin/syringe, eye drops, inhalers; -Residents requesting to self-administer hand held nebulizers will be required to demonstrate their ability to safely and effectively use the hand?held nebulizers without the assistance of a Licensed Nurse; -Agree to comply with Facility policy related to the self-administration of medication. -The Licensed Nurse will inspect the contents of the medication containers for evidence that the resident may not unable to self-administer medications (i.e., non-drug items stored in pill container, different medications mixed together, medications which have expired or appear to be deteriorating) -If the resident is assessed as clinically appropriate for medication self-administration, by the Interdisciplinary team (IDT), the Licensed Nurse obtains a physician's order for self-administration of selected medications; -The resident's record should contain documentation that demonstrates that he/she was part of the IDT process in determining whether self-administration is safe and appropriate; -Medications specifically excluded from self-administration for any reason must be specified in the Attending Physician's order; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Self-administration is only permitted if approved in writing by the Attending Physician, which may be in the form of an order; -The IDT develops and implements a care plan for medication self-administration; -This care plan is reviewed at least quarterly with each reassessment based on OBRA timeframes; -The care plan will identify: -Where the medications are stored; -Education for resident/family regarding medication self-administration process, specific medication information and safe, effective use of medications; -Obtaining medication; -Administering medication according to physician order; -How Licensed Nurses will validate that medications are taken as ordered by the attending physician; -How non-compliance and/or refusal to take medications will be managed; -If the IDT and Attending Physician do not approve self-administration of medications, the resident or their representative will be informed, and the reason will be documented in the medical record; -If the IDT team and Attending Physician approve self-administration of medications, the medications will be placed in a secured drawer or cabinet that is easily accessible to the resident; -Controlled drugs (i.e., narcotics, hypnotics, etc.) are not to be left for open access to the resident; -The Administrator/Director of Nursing Services or designee ensures the resident has access to a secure container for proper medication storage if the medications are not stored on the medication cart; -The Licensed Nurse on each shift ensures that medications are taken as ordered by the Attending Physician and documents on the MAR; Refusals and/or non-compliance with self-administration of medications as ordered by the Attending Physician is documented on the MAR and in the nurses' notes; -All self-administered medications will have pharmacy labels with complete directions for use of the medication; -No labels may read as directed; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Non-prescription (over the counter, OTC) medications may be allowed if the medical label is intact; -A resident may withdraw from being able self-administer medications at any time; -Residents will be re-evaluated if any member of the IDT suspects non-compliance with the self-administration authorization or any change in the resident's cognitive status; -The Attending Physician is notified of habitual and/or frequent non-compliance or refusal of medication self-administration; -In the case of suspected medication non-compliance (e.g. dosage in excess of the amount anticipated, loss of therapeutic control or suspected drug toxicity) the nursing staff will complete an assessment. The Attending Physician will be notified if the resident is no longer deemed appropriate for self-medication administration. The Licensed Nurse will obtain orders as necessary; -Documentation: The physician's order approving the self-administration of medication will be maintained in the resident's medical record; -The Assessment for self-Administration of Medications will be maintained in the resident's chart; -Self-administration of medications will be documented in the resident's Care Plan and the MAR. 1. Review of Resident #22's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included anemia, aphasia (language disorder), cerebral palsy (congenital disorder of movement, muscle tone, or posture), dementia, quadriplegia (paralysis of all four limbs), seizure disorder; -Impairment on both sides of the upper and lower extremities; -Weight of 97 pounds; -Feeding tube; -51% or more total calories received through parenteral (nutrition given through the vein) or tube feeding; -Average fluid intake per day by tube feeding: 500 cubic centimeters (cc) or more. Review of the resident's care plan, in use during the survey, showed: (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Focus: Resident has history of diagnosis aspiration pneumonia (occurs when food or liquid is breathed into the airways or lungs) at risk for respiratory complications. Shortness of breath returned on [DATE], with tube feeding continues, has history of drooling [DATE] diagnosis of postnasal drip, diagnosis of dysphagia (difficulty swallowing) [DATE]. Weight lost noted. History of g-tube becoming dislodged. History of nausea and vomiting. History of weight variances; -Goal: Resident will have clear lungs, no signs and symptoms of aspiration; -Interventions: Assess level of care every shift and as needed (PRN); -Change tube feeding formula to 2 CAL HN (calorie and protein dense nutrition to support patients with volume intolerance and/or fluid restriction) related to emesis (vomiting) and increase residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding); -Check for aspiration, hold tube feeding if residual greater than 60 cc and inform physician; -Cleanse g-tube site daily and cover with dry dressing; -Dietician to evaluate as needed; -Flush g-tube as ordered; -Head of board (HOB) elevated at 45 degrees at all times; -Medication as ordered for nausea/vomiting; -Monitor for shortness of breath, choking, labored respirations, lung congestion; -Monitor input every shift; -Monitor tolerance to tube feedings; -Nothing by mouth (NPO); -Scopolamine (a medication used to manage and treat postoperative nausea and vomiting and motion sickness) patch every 72 hours; -Sent to hospital for g-tube replacement. Review of the resident's Physician's Orders Sheet (POS), dated [DATE] showed: -An order, dated [DATE], cleanse g-tube site with normal saline (NS)/DWD (dermal wound cleanser); cover with dry dressing every night shift for g-tube; -An order, dated [DATE], check residual, if greater than 60 cc hold feeding and call physician every shift for enteral feeding; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order, dated [DATE], for Scopolamine patch 72 hour. Apply one application transdermal every 72 hours for drooling; -An order, dated [DATE], for Vitamin D liquid. Give 2000 unit via g-tube one time a day for vitamin D deficiency; -An order, dated [DATE], for Glycolax Powder (Polythylene Glycol 3350, used to treat constipation). Give 17 gram via PEG-tube one time a day for constipation. Mix with 6 ounces of water until completely dissolved; -An order, dated [DATE], for Senna Syrup (used to relieve constipation). Give 8.6 mg via g-tube two times a day for constipation; -An order, dated [DATE], Multivitamin Liquid (multiple vitamins-minerals). Give 5 ml via PEG-tube one time a day for vitamin deficiency; -An order, dated [DATE], for Keppra (used to treat seizures) Solution 100 milligram (mg). Give 10 ml via g-tube three times a day for seizures; -An order, dated [DATE], enteral feed every shift. Hold tube feeding one hour after each medication pass every shift; -An order, dated [DATE], enteral feed, three times a day, 30 ml water before and after medication; -An order, dated [DATE], g-tube charting to include inspection of site, how the g-tube flushes, any redness/pain/drainage, toleration of feeding and medications every shift for g-tube charting; -An order, dated [DATE], for Valproic Acid (anticonvulsant to treat seizures) solution. Give 30 milliliters via g-tube three times a day for seizure; -An order, dated [DATE], ensure HOB is elevated at 45 degree angle at all times. Hold tube feeding pump for any activities of daily living (ADLs) requiring flat bed. Run tube feeding pump after patient is re-positioned at 45 degrees after ADLs every shift for prevention of aspiration; -An order, dated [DATE], for 2 CAL tube feeding at 40 ml/ hr continuously per pump every shift for g-tube feeding status; -An order, dated [DATE], enteral feed every 4 hours. Free water flush 175 ml every four hours. Push slowly he/she has a history emesis. Monitor tolerance. (continued on next page)

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

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on [DATE] at 10:19 A.M., showed the resident in his/her room. He/She lay in the bed, which was lowered to floor. The HOB was at 45 degrees and his/her eyes were closed. The resident was covered with a blanket. The tube feeding machine showed it was on hold and beeped continuously. The tube feeding stand showed 2.0 CAL container hung with handwritten documentation ,d+[DATE] at 3:00 A.M., and 40 cc on the bottle. A full flush bag was hung with handwritten documentation [DATE]. The tubing was not connected, and lay across on the tube feeding stand. The end was not capped or covered. At 10:44 A.M., no beeping was heard from tube feeding machine upon entering room. The tubing was connected to the resident and the tube feeding machine showed it was set to infuse at 40 ml/ hr. The flush showed 175 ml every four hours. There was approximately 750 cc of fluid remaining in the 2.0 CAL bottle. There was dried tube feeding fluid on the floor around the tube feeding stand and on the metal stand. The resident had dried white substance around his/her facial hair. At 4:53 P.M., there was approximately 550 cc of fluid remaining in the 2.0 CAL bottle. The machine showed it was infusing at 40 ml/ hr and 175 cc of flush every four hours. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on [DATE] at 7:56 A.M., showed the resident in bed, positioned on his/her left side. There was approximately 900 cc remaining in the 2.0 CAL bottle that was hung. The tube feeding machine screen showed the settings were not in English language. There were no words written in English on the screen. The machine showed a rate of 140 ml/hr. There was no written documentation on the 2.0 CAL bottle or flush bag. The flush bag showed approximately 600 cc remaining. At 10:46 A.M., staff was in the room with the resident. Certified Nurse Aide (CNA) V said he/she provided the resident with peri care. The resident was in bed with eyes closed. The tube feeding machine screen showed no words in the English language and a rate of 140 ml/hr. There was approximately 500 cc of fluid left in the 2.0 CAL bottle. At 11:01 A.M., upon entering room, CNA V said the resident just vomited. There was a small amount of emesis on the resident's lower half of face and neck which was a light beige in color. The resident continued to cough until thick saliva excreted from his/her mouth onto his/her lower face, neck, and bed pillow. At 11:03 A.M., the surveyor asked Licensed Practical Nurse (LPN) S to assess the g-tube machine. LPN S was asked if the 140 ml/hr on the machine was correct. He/She said the tube feeding was not supposed to be at 140 ml/hr. He/She did not work on the floor often, but the last time the rate was 40 or 60 ml/hr. CNA V began to clean the resident's face. LPN S was asked to check the residual. LPN S attempted to change the settings on the g-tube machine, but was not successful. LPN S turned off the g-tube machine and exited the room to get supplies. There was tube feeding fluid on the floor next to the stand. The Assistant Director of Nursing (ADON) BB entered the room and assessed the g-tube machine. She did not know what language the g-tube machine was set on. She attempted the change the settings, and was successful with changing the language setting back to English. ADON BB later exited the room. LPN S returned to the room and disconnected the tube feeding from the resident to complete the residual check. The syringe showed approximately 10 ml of fluid. LPN S said night shift is responsible for hanging the g-tube and checking the settings on the machine. The machine stops when the bottle is empty on night shift. The resident has a history of aspiration. He/She also becomes dizzy and nauseous, that was why he/she had the sticker behind his/her ear. If he/she received 140 ml/hr of feeding, he/she would have projectile vomiting. The resident was observed with a round sticker behind his/her ear. LPN S began to press buttons on the tube feeding machine and cleared the machine. The settings were returned to English. LPN S exited the room to report to the Director of Nursing (DON). At 11:18 A.M., the resident began to cough and gag until he/she vomited. The light beige colored vomit poured out of the resident's mouth, covering his/her upper torso. At 11:20 A.M., LPN S entered the room and saw the emesis. He/She said the emesis was the same color as the tube feeding and the resident threw up half the bottle. LPN S said the emesis was definitely from the tube feeding. LPN S checked the resident's vitals. The resident's oxygen saturation was 93% on room air, heart rate showed 112, the blood pressure was ,d+[DATE] and his/her temperature was 97.5 degrees Fahrenheit (F). LPN S said they may have to send the resident to the hospital because the g-tube was infusing at 140 cc/hr and he/she had a history of aspiration. At 11:29 A.M., Restorative Aide W and CNA V entered the room. ADON BB entered the room with a suction machine. Restorative Aide W started to clean the resident and said (he/she) never vomited like this before. This is not normal. At 11:40 A.M., LPN S said he/she spoke to the Nurse Practitioner and reported the resident threw up half the bottle. The resident will be transported to the hospital. LPN B came into the room and assessed the resident's lung and bowel sounds. He/She said the lungs sounded clear. LPN B said he/she gave the resident's g-tube medication at 8:40 A.M. Review of the resident's MAR, dated [DATE] and [DATE], showed: -An order, dated [DATE], cleanse g-tube site with NS/DWD; cover with dry dressing every night shift for g-tube, showed completed on [DATE], during the night shift by LPN C; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order, dated [DATE], enteral feed every four hours free water flush 175 ml every four hours. Push slowly he/she has a history emesis and monitor tolerance was documented as administered on [DATE] at 1:00 A.M. and 5:00 A.M. by LPN C; -An order, dated [DATE], for Valproic Acid solution. Give 30 milliliters via g-tube three times a day for seizure was documented as administered on [DATE] at 6:00 A.M. by LPN C; -An order, dated [DATE], to change graduate and syringe daily one time a day was documented as completed on [DATE] at 6:00 A.M. by LPN C. During an interview on [DATE] at 6:42 A.M., LPN C said he/she worked the night shift. The night shift staff hang the tube feeding if ordered as continuous. He/She did not notice it was in a weird language and the rate of the feeding is preset. LPN C said all you should be pressing is the run or stop. The resident did not have any vomiting during the shift. The feeding normally runs at 40 ml/hr. Sometimes the aides will stop the machine when they provide care and then restart the feeding after care. The feeding should run slowly since the resident is prone to vomiting. Review of the resident's MAR, dated [DATE], showed: -An order, dated [DATE], enteral feed, three times a day, 30 ml water before and after medication documented as administered on the day shift by LPN B; -An order, dated [DATE], enteral feed every 4 hours free water flush 175 ml every four hours. Push slowly he/she has a history emesis. Monitor tolerance was documented as administered at 9:00 A.M. by LPN B; -An order, dated [DATE], for Senna Syrup. Give 8.6 mg via g-tube two times a day for constipation was documented as administered at 9:00 A.M. by LPN B; -An order, dated [DATE], for Vitamin D liquid. Give 2000 unit via g-tube one time a day for vitamin D deficiency was documented as administered at 9:00 A.M. by LPN B; -An order, dated [DATE], for Glycolax Powder (Polythylene Glycol 3350). Give 17 gram via PEG-tube one time a day for constipation. Mix with 6 ounces of water until completely dissolved was documented as administered at 9:00 A.M. by LPN B; -An order, dated [DATE], Multivitamin Liquid (multiple vitamins-minerals). Give 5 ml via PEG-tube one time a day for vitamin deficiency was documented as administered at 9:00 A.M. by LPN B; -An order, dated [DATE], for Keppra Solution 100 milligram (mg). Give 10 ml via g-tube three times a day for seizures as documented as administered at 9:00 A.M. by LPN B. Review of the resident's MAR, dated [DATE], showed: -An order, dated [DATE], for 2 CAL tube feeding at 40 ml /hr continuously per pump every shift for g-tube feeding status documented as completed on the day shift by LPN A; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-An order, dated [DATE], check residual, if greater than 60 cc hold feeding and call physician every shift for enteral feeding documented as completed on the day shift by LPN A; -An order, dated [DATE], ensure HOB is elevated at 45 degree angle at all times. Hold tube feeding pump for any ADLs requiring flat bed. Run tube feeding pump after patient is re-positioned at 45 degrees after ADLs every shift for prevention of aspiration documented as completed on the day shift by LPN A; -An order, dated [DATE], enteral feed every shift. Hold tube feeding one hour after each medication pass every shift documented as completed on the day shift by LPN A; -An order, dated [DATE], G-Tube charting to include inspection of site, how the g-tube flushes, any redness/pain/drainage, toleration of feeding and medications every shift for g-tube charting documented as completed on the day shift by LPN A. During an interview on [DATE] at 1:36 P.M., LPN A said he/she worked the day shift and arrived at 7:30 A.M. after night shift left. When he/she arrived, report was received from LPN C. LPN A did not notice problems with the g-tube machine LPN C reported to LPN A that the resident had emesis during the night shift. LPN B started the tube feeding and they normally cut the g-tube machine off at that time LPN A said he/she worked on the South end at the time the feeding. LPN A was not aware of any issues with the machine. LPN A later clarified his/her statement and said he/she was in the room with LPN C when LPN C hung the 2.0 CAL bottle. LPN C hung the tube feeding bottle and made sure the water was there. LPN A said he/she did not look at the tube feeding machine. He/She only looked at the resident to check if he/she was breathing. LPN C also did not report anything to LPN B at that time. LPN C came out of the room and started giving report. LPN A said if he/she saw a g-tube did not have correct setting for infusion or if the settings were in a different language, he/she would shut down the machine. LPN A said he/she did not know how to change the settings, so he/she would shut it down and report to the ADON or DON. LPN A would go back to the medical record and check the physician's orders. The resident has a history of emesis and has it all the time. LPN A said he/she did not check the resident's residual. LPN B checked it. LPN A was not in the room with LPN B at the time and was not sure if there was any residual. LPN A said they had a skilled check list they had to complete. During an interview on [DATE] at 2:07 P.M., LPN B said he/she saw the resident this morning. LPN B confirmed the screen on the tube feeding machine was set in a language that he/she did not understand. He/She shut the machine off at 10:00 A.M. because it was in another language. LPN B did not report it because there was an emergency with another resident who was calling for the nurse. He/She could not recall what the rate settings were on the tube feeding machine, but did not remember seeing it set to infuse at 140 ml/ hr. He/She administered the resident's medication right before 10:00 A.M. The resident had approximately 25 ml of residual. There was no gagging, vomiting, or coughing. LPN B did turn the machine off, but did not turn it back on. The next time he/she saw the resident, it was at 11:30 A.M. and the nurses were in the room at the time. He/She did not know who turned the machine back on. LPN B did not have orientation or in-service/education prior to [DATE]. Review of the resident's hospital record, dated [DATE], showed: -Reason for visit: Nausea and vomiting; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnosis: Nausea and vomiting; -Provider notes: Resident with past medical history significant for cerebral palsy, quadriplegia, seizures, and anemia. Sent to the emergency room for nausea and vomiting. Patient is non-verbal and contracted baseline. Per Emergency Medical Service (EMS), too much feeding today. Patient was also given an additional 100 ml and vomited. Patient appears to be stable at this time; -X-ray (used to generate images of tissues and structures inside the body) of the chest and computed tomography (CT, a medical imaging technique used to obtain detailed internal images of the body) scan of abdomen and pelvis were unmarkable. Will discharge patient back to facility. During an interview on [DATE] at 6:30 A.M., LPN GG said the resident receives continuous tube feeding. He/She has occasional emesis. Night shift nurses are responsible for g-tube care, such as changing out dressings, syringes, and inspecting the tube feeding sites. When a resident has orders for continuous tube feeding, 23 hours on and one hour off, the hour off is to account for time used for medication administration. He/She has not been in-serviced recently on tube feeding. During an interview on [DATE] at 10:00 A.M., the DON said the licensed nurses are responsible for hanging the tube feeding container and ensuring the machine settings and infusion rates are accurate, but the resident is on a continuous feed, so nursing should check the machine. If nursing completed their rounds, they would know if there was an issue with the machine. It was reported to the DON on [DATE] at 10:50 A.M. that the resident's machine was set in another language and set to infuse at 140 ml/hr. It is not acceptable for nursing to document tube feeding orders, treatments, and check and assess the resident and machine settings on the MARs if it was not done. Nursing is expected to check the MAR, orders, and placement. It is not acceptable to document it if it was not completed. It was not reported to the DON that the machine was turned off. When it was reported, the ADON got the machine back in English. There were no reports of CNAs changing the machine. If a CNA was providing care, they can pause it. She expected nursing to have reported the machine was set in another language when it was discovered. She expected the 2.0 CAL bottle to have documentation of the date, infuse rate, time it was hung, and staff initials. The DON said the results of the g-tube infusing at 140 ml/hr instead of 40 ml/hr could have a fatal outcome. During an interview on [DATE] at 11:51 A.M., Nurse Practitioner (NP) X said it was reported to him/her this morning the resident went to the hospital on [DATE]. He/She said 140 ml/hr was a big jump. It was too high and there is an aspiration risk, but it depends on the resident's size and position. He/She expected nursing to follow physician's orders. During an interview on [DATE] at 7:29 A.M., LPN S said the infuse rate of 140 ml/hr was too much. The resident is tiny and he/she could barely tolerate 40 ml/hr. Observation on [DATE], [DATE], [DATE] and [DATE], showed: -On [DATE] at 7:41 A.M., showed the resident in bed. Tube feeding infuse rate set at 40 ml/hr. There was a full container of 2.0 CAL with handwritten with only date of ,d+[DATE]. There was approximately 400 cc remaining in the flush bag, with a handwritten date of ,d+[DATE]; (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE] at 10:50 A.M., the resident was in bed with eyes open. Tube feeding infuse rate set at 40 ml/hr. There was approximately 900 cc of fluid remaining in the 2.0 CAL bottle. The bottle was hung without any handwritten documentation of date, time, rate, or staff initials. There was approximately 480 cc of water in the flush bag. The flush bag did not have any written documentation; -On [DATE] at 11:00 A.M., the resident was in bed with his/her eyes closed. Tube feeding infuse rate set at 40 ml/hr. There was approximately 450 cc of fluid remaining in the 2.0 CAL bottle. The bottle was hung with handwritten documentation that showed a date of ,d+[DATE] and 40 ml. There was approximately 450 cc of water in the flush bag. The flush had written documentation that showed a date of ,d+[DATE] and 175 ml. The time was not documented on the 2.0 CAL bottle or flush bag. -On [DATE] at 8:25 A.M., the resident was in bed with eyes open. Tube feeding infuse rate was set at 40 ml/hr. There was approximately 700 cc of fluid remaining in the 2.0 CAL bottle. The bottle was hung with handwritten documentation that showed [DATE] at 10:00 P.M. and 40 ml/hr. There was approximately 700 cc of water remaining in the flush bag. There was no handwritten documentation on the flush bag. During an interview on [DATE] at 11:18 A.M., the Administrator and DON said they expected nursing to check the tube feeding machine and ensure the infuse rate displayed is accurate upon entering room. They expected nursing to document the 2.0 CAL bottle with date, rate, time it was hung, and staff initials. They expected staff to follow physicians orders and accurately document on the MARs/TARs. During an interview on [DATE] at 3:30 P.M., the Administrator said the facility did not have a policy and procedures that addressed how to set up the tube feeding pump, hanging the feeding container, or expectations for nursing staff. 2. Review of Resident #45's quarterly MDS, dated [DATE], showed the following: -Diagnoses included severe protein-calorie malnutrition (inadequate intake of food containing calories and proteins), anorexia, gastroparesis (muscles in the stomach not functioning properly which causes the stomach to not empty), gastric ac

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 37672 Based on observation, interview and record review, the facility failed to ensure a resident with chronic obstructive pulmonary disease (COPD, a chronic lung disease which airflow is constricted and makes it difficult to breathe) symptoms, received ordered oral steroids. The resident continued to have audible wheezing and the facility obtained a STAT (immediate) chest x-ray. The facility did not obtain or report the results to the physician and the x-ray results reflected pneumonia. The resident experienced a change in condition on 7/13/24, was sent to the hospital, where he/she received steroids. He/She was diagnosed with a COPD exacerbation and ordered steroids and two separate antibiotics (Resident #4). In addition, the facility also failed to obtain physician orders for continuous positive airway pressure machines (C-PAP, a machine which provides a mild continual airflow pressure to maintain an open airway, used to treat sleep apnea) for two residents diagnosed with sleep apnea (sleep disorder in which breathing repeatedly stops and starts) (Residents #42 and #89). The census was 151. Review of the physician order policy, revised 10/24/22, showed: -Purpose: To ensure that all physician orders are complete and accurate; -Policy: Medical record department will verify that physician orders are complete, accurate and clarified; -Procedure: Physician orders will include the following: -Name of the medication, treatment; -Dosage, frequency and duration of the order; -The route, condition and diagnoses for which the medication/treatment is ordered. 1. Review of Resident #4's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/15/24, showed: -readmitted : 1/22/23; -Severe cognitive impairment; -Upper and lower extremity paralysis; -Staff provide substantial to maximum assistance for toileting, transfers, dressing and hygiene; -Diagnoses included: stroke, cancer, heart failure, vascular disease, diabetes, dementia, and COPD; -No respiratory therapy provided in the last seven days; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-No respiratory treatments provided. Review of the care plan, in used during the survey, showed: -Focus: The resident has a diagnosis of COPD and is at risk for shortness of breath and respiratory failure related to lung cancer; -Goal: The resident will be free of respiratory infection; -Interventions: Staff administer respiratory medications as ordered, monitor for difficulty breathing, monitor and document any signs of respiratory infection and notify the nurse and physician of changes. Review of the progress notes showed: -On 6/26/24 at 10:41 A.M., a nurse note: The resident complained of shortness of breath. Oxygen saturation at 90% (normal 90-100% breathing room air). Breathing treatment given per orders. Nurse practitioner (NP) onsite, assessed the resident and new orders given for chest x-ray; -On 6/26/24 at 2:07 P.M., a nurse note: The resident refused breakfast and lunch. Snacks offered and declined. Staff offered and encouraged fluids, the resident stated he/she was not hungry; -On 6/26/24 at 6:35 P.M., a nurse note: Chest x-ray results received, diagnoses of pneumonia. New orders received: Vantin (antibiotic) 100 milligrams (mg) twice a day for seven days and Medrol dose pack (a titration lowering medication dose) as directed: (4 mg dose pack schedule: Day 1: take 2 tablets before breakfast, 1 after lunch, 1 after dinner, 2 at bedtime; Day 2: take 1 tablet before breakfast, 1 after lunch, 1 after dinner, 2 at bedtime; Day 3: take 1 tablet before breakfast, 1 after lunch, 1 after dinner, 1 at bedtime; Day 4: take 1 tablet before breakfast, 1 after lunch, 1 at bedtime; Day 5: take 1 tablet before breakfast and 1 at bedtime; Day 6: take 1 tablet before breakfast. Review of the electronic physician order sheet (ePOS), showed an order, dated 6/27/24: Medrol (used to treat inflammation) tablet 4 mg. Review of the June Medication Administration Record (MAR), showed: -An order, dated 6/27/24: -Medrol 4 mg: Give 2 tablets in the morning, scheduled at 9:00 A.M., documented as 9 or see progress notes; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Medrol 4 mg: Give 1 tablet in the afternoon, scheduled at 12:00 P.M., documented as 9, or see progress notes. Review of the progress notes on 6/27/24 at 2:51 P.M., showed a nurse note: Medrol 4 mg, awaiting pharmacy delivery. Review of the June MAR, showed: -An order, dated 6/27/24: -Medrol 4 mg: Give 1 tablet in the evening, scheduled at 5:00 P.M., documented as given; -Medrol 4 mg: Give 2 tablets at bedtime, scheduled at 9:00 P.M.,, documented on 6/27/24 as given; -An order, dated 6/28/24: -Medrol 4 mg: Give 1 tablet in the morning, scheduled at 9:00 A.M., documented as given; -Medrol 4 mg: -Medrol 4 mg: Give 1 tablet in the afternoon, scheduled at 12:00 P.M., documented as given; -Medrol 4 mg: Give 1 tablet in the evening, scheduled at 5:00 P.M., documented as given; -Medrol 4 mg: Give 2 tablets at bedtime, scheduled at 9:00 P.M.,, documented as given; -An order, dated 6/29/24, showed: -Medrol 4 mg: Give 1 tablet in the morning, scheduled at 9:00 A.M., documented as given; -Medrol 4 mg: Give 1 tablet in the afternoon, scheduled at 12:00 P.M., documented as given; - Medrol 4 mg: Give 1 tablet in the evening, scheduled at 5:00 P.M., documented as given; - Medrol 4 mg: Give 1 tablet at bedtime, scheduled at 9:00 P.M., documented as given; -An order, dated 6/30/24, showed: -Medrol 4 mg: Give 1 tablet at 9:00 A.M., 12:00 P.M., and 9:00 P.M., documented as given. Review of the July MAR, showed: -An order, dated 7/1/24: -Medrol 4 mg: take 1 tablet at 9:00 A.M., 12:00 P.M., documented as given on 7/1/24 and 7/2/24. Review of the progress notes, showed on 7/5/24: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few	-At 12:53 P.M., a nursing note: The resident observed with abdominal breathing, family at bedside. The resident denies shortness of breath. Breathing treatment given. Physician notified; -At 1:07 P.M., the physician provided new orders for a STAT chest x-ray and Prednisone (anti-inflammatory) at 50 mg day 1, 40 mg day 2, 30 mg day 3, 20 mg day 4, 10 mg day 5, then discontinue. Review of the nurse practitioner visit note, dated 7/5/24 at 8:30 P.M., showed: -Chief complaint: Completed antibiotics for pneumonia on 7/4/24, with reported shortness of breath. Increased shortness of breath and abdominal muscle use; -Duration: Chronic condition; -Respiratory: Complaint of dyspnea (shortness of breath, difficulty breathing), accessory abdominal muscle use, non-productive cough, shallow respirations, diminished breath sounds and mild expiratory wheezing; -Labs: STAT chest x-ray ordered; -Plan: New order Prednisone 10 mg burst- give 50 mg one time a day, then taper off. Medrol 4 mg- give 2 tablets at bedtime for COPD and Trelegy Elliptia inhalation (bronchodilator, opens lung airways) 1 inhalation once a day for COPD. Review of the ePOS, showed: -An order, dated 7/5/24: Ipratropium-albuterol inhalation (used to treat shortness of breath, and open the airways) 0.5-2.5 mg/3 milliliter (ml) solution. Inhale 3 ml twice a day; -An order, dated 7/5/24: STAT chest x-ray. Review of the progress note, showed: -On 7/5/24 at 11:13 P.M., a nursing note: X-ray technician here to obtain chest x-ray. Results pending. No signs or symptoms of distress noted. Review of the ePOS, showed an order, dated 7/5/24: Medrol 4 mg, give 2 tablets a day at bedtime. Review of the July 2024 MAR, showed: - An order, dated 7/5/24: Medrol 4 mg, give 2 tablets a day at bedtime at 9:00 P.M.,; -Documented as given on 7/1/24 and 7/2/24; -Documented as 9 or see progress notes on: 7/3/24 and 7/4/24; -No progress note documented to reflect the non-administration on 7/3/24 or 7/4/24. Review of the July MAR, showed: (continued on next page)

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	265585	A. Building B. Wing	07/16/2024

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-An order dated, 7/6/24 for: Prednisone give once a day at 9:00 A.M., scheduled: -Prednisone 50 mg day 1, on 7/6/24: blank, undocumented; -Prednisone 40 mg day 2, on 7/7/24: blank, undocumented; -Prednisone 30 mg day 3, on 7/8/24: blank, undocumented; -Prednisone 20 mg day 4, on 7/9/24: blank, undocumented: -Prednisone 10 mg day 5, on 7/10/24: blank, undocumented; -Prednisone 5 mg day 6, on 7/11/24: blank, undocumented. Review of the progress notes, showed: -On 7/6/24 at 8:20 P.M., a nurse note: Medrol 4 mg- medication not available; -On 7/8/24 at 12:11 P.M., a nurse note: Nurse practitioner notified of missing Prednisone on the dates of 7/6/24 and 7/7/24. No new orders received; -No documentation regarding STAT chest x-ray results. During an interview on 7/8/24 at 2:02 P.M., the resident's next of kin (NOK) said the resident was diagnosed with pneumonia and recently finished antibiotics. He/She wanted another chest x-ray done earlier in the week and had not be told the results. The NOK said he/she was very concerned because he/she could hear the resident wheezing and a wet cough. The nursing staff were unable to tell him/her if the x-ray had been completed or if the results were reported. He/She was concerned the pneumonia is not completely treated. Review of the progress notes, showed: -On 7/8/24 at 8:46 P.M., a nurse note: Medrol dose pack completed; -On 7/10/24 at 8:37 P.M., a medication note: Medrol 4 mg - medication pending from pharmacy. During an interview on 7/11/24 at 10:26 A.M., the NP said he was familiar with the resident's care. The resident has a history of COPD and chronic pneumonia. He expected staff to administer medications as ordered. If a medication were not available, he expected staff to notify the physician or the NP. Prednisone is a steroid used to reduce inflammation. After checking communications with the facility, the NP said the office had not been notified of the chest x-ray results from 7/5/24 or the missed Prednisone doses from 7/6/24 thru 7/11/24. Review of the progress notes, showed: -On 7/13/24 at 4:02 A.M., the resident complained of pain, Tylenol (pain reliever) given. Audible wheezing heard. Oxygen saturations at 91% room air. Breathing treatment given. Head of bed elevated; (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-On 7/13/24 at 4:15 A.M., the resident further assessed. Noted to have abdominal breathing, wheezing, moist lung sound, gurgling and desating (oxygen levels drop) physician called and message left. Oxygen saturation dropped to 85%, head of bed at high position, oxygen started at 3 liters per minute (LPM)/ nasal cannula (NC, hollow tube to the nose, used to deliver oxygen); -On 7/13/24 at 4:30 A.M., a weekly skin note: skin assessment done, bed bath given before resident left; -On 7/13/24 at 4:32 A.M., a nurse note: Ambulance called for transportation to emergency room (ER) for evaluation and treatment. Arrival approximately 20 minutes; -On 7/13/24 at 4:50 A.M., a nurse note: Ambulance arrived, resident to ER; Review of the hospital visit summary, dated 7/13/24, showed: -Reason for visit: Shortness of breath; -Diagnosis: COPD exacerbation; -Discharge medications: -Amoxicillin 875-125 (combination antibiotic) mg: Take one tablet every 12 hours; -Azithromycin (antibiotic) 250 mg: Take 2 tablets for one day, then 1 tablet daily for 4 days, start taking on 7/13/24; -Prednisone 20 mg: Take 40 mg daily for 4 days-start taking on 7/13/24. Review of the progress notes, showed: -On 7/13/24 at 11:17 P.M., nursing note: The resident alert and responsive. Assisted to bed by two staff. Coarse lung sounds and breathing treatment given as ordered. Oxygen saturation at 93% room air. The nurse notified the NOK no new medications were ordered. Review of the ePOS, showed: -An order, dated 7/14/24: Prednisone 40 mg, take one tablet daily for 4 days; -An order, dated 7/14/24: Azithromycin 250 mg, take 2 tablets for one day, then 1 tablet daily for 4 days; -An order, dated 7/14/24: Amoxicillin 875-125 mg, take one tablet every 12 hours. Review of the progress notes, dated 7/14/24 at 5:42 P.M., showed a nursing note: -Prednisone 40 mg tablet- give one every evening for respiratory infection. Medication pulled from E-kit (emergency medication supply); (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-This administration was not documented on the July MAR; -Amoxicillin 875-125 mg-give one tablet every 12 hours for 4 days. Medication pulled from E-kit; -At 8:57 P.M., the resident remains on antibiotics and Prednisone. Denies pain and no signs or symptoms of discomfort. Review of the July 2024 MAR, showed: -An order, dated 7/14/24: Prednisone 40 mg: take one every evening for respiratory infection. Documented as zero 0, on 7/14/24, 7/15/24. Documented as 5 or digoxin (heart medication) level on 7/16/24. -An order, dated 7/14/24: Amoxicillin 875-125 mg. Give 1 tablet every 12 hours for 4 days for respiratory infection. Documented as administered at 9:00 A.M., and 9:00 P.M., daily; -An order, dated 7/15/24: Azithromycin 250 mg: take 1 in the morning for respiratory infection. Documented as administered at 9:00 A.M., on 7/14/24, 7/15/24, 7/16/24 and 7/18/24; On 7/15/24 at 9:25 A.M., the Regional Nurse provided the chest x-ray, completed on 7/5/24 at 4:41 P.M. The results are as follows: -Date of service: 7/5/24; -Time: 4:41 P.M., -Indication: Congestion; -Findings: Patchy infiltrates in the left upper and lower lobe; -Impression: Patchy left sided pneumonia; -No physician signature or acknowledgement of the results. During an interview on 7/16/24 at 11:16 A.M., the Director of Nursing (DON) and Administrator said after review of the chest x-ray results from 7/5/24, it appeared the physician was not notified of the results. Staff should follow up with the imaging results the next day or if ordered STAT, within a few hours of the testing. If ordered medications are not available, staff should pull the medication from the E-kit. If the medication is not available in the E-kit, the pharmacy should be called for an emergency delivery. Staff should notify the physician or nurse practitioner if medications are not available or missed. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/17/24 at 3:10 P.M., the resident's Physician said the resident has lung cancer, COPD exacerbation and chronic pneumonia. He did not receive any communications from the facility regarding missed medication doses or the STAT chest x-ray results. He expected staff to follow up with the imaging company for results and report those to him or the NP. If medications are not available at the facility, the pharmacy should be called. The DON and Administrator should obtain the medications. He should be notified to order a different medication if needed. Prednisone is used to reduce inflammation quickly. The resident should have received the Prednisone, but he/she did receive the antibiotics. The Physician is unsure if the Prednisone would have prevented the change in condition or hospitalization . 2. Review of Resident #42's quarterly MDS, dated [DATE], showed: -No cognitive impairment; -Diagnoses include heart failure, high blood pressure, asthma, respiratory failure; -Receives oxygen therapy. Review of the resident's care plan, in use during survey, showed: -Focus: COPD, C-PAP used during resting hours due to shortness of breath; -Interventions: Resident will use C-PAP during his/her resting hours; -Monitor his/her oxygen saturation as directed. Review of the resident's ePOS, dated July 2024, showed: -An order, dated 5/28/24: Does the resident experience shortness of breath while lying flat or avoids lying flat (utilizes pillows) due to shortness of breath? Every shift for COPD; -An order, dated 5/28/24: Resident is at risk for malnutrition related to COPD, atrial fibrillation (Afib, abnormal heartbeat), congestive heart failure (CHF), rheumatoid arthritis (RA), high blood pressure. Interventions: Registered Dietician (RD) to evaluate as needed, weights as needed, labs as needed, medications as ordered; -No physician's orders for use of the C-PAP machine. Review of the resident's July 2024 MAR, showed: -Does the resident experience shortness of breath while lying flat or avoids lying flat (utilizes pillows) due to shortness of breath? Every shift for COPD, showed: -On 7/1, 7/3, 7/4, and 7/7/24 at 6:00 A.M., staff documented yes; -On 7/9 and 7/10/24 at 2:00 P.M., staff documented yes; -On 7/1 through 7/11/24 at 10:00 P.M., showed no shortness of breath. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 7/11/24 at 9:15 A.M., showed resident in room, in bed. The resident had a C-PAP machine on the night table. He/She said the aides assist him/her every night with the C-PAP. The mask lay on the night table, uncovered. Observation on 7/15/24 at 10:49 A.M., the resident's C-PAP mask on the resident's bed uncovered. The machine lay on the resident's night table. It was not in use. During an interview on 7/15/24 at 3:00 P.M., Licensed Practical Nurse (LPN) SS said sometimes staff assist with the C-PAP or the resident can do it him/herself. The resident is still awake when LPN SS leaves at 11:00 P.M., so he/she is not using it yet. During an interview on 7/16/24 at 8:28 A.M., the resident said he/she uses the C-PAP every night. He/She turned off the machine at 7:00 A.M. and starts it at 11:30 P.M. The aides put water in the machine and they turn it on. The CPAP mask was uncovered on top of the seat of the resident's wheelchair. 3. Review of Resident #89's annual MDS, dated [DATE], showed: -No cognitive impairment; -Diagnoses included: heart failure, hypertension (HTN, high blood pressure), hyperlipidemia (HLD, high level of lipids (fat particles) in the blood), diabetes, malnutrition, anxiety, bipolar (mental disorder where the person experiences manic highs to depressive lows), and asthma; -Received oxygen. Review of the resident's care plan, in use during survey, showed: -Focus: Resident has a diagnosis of COPD; -Interventions: Resident uses Bilevel positive airway pressure (bi-pap, machine that helps with breathing) at bedtime related to COPD and obstructive sleep apnea. Review of the resident's ePOS, dated July 2024, showed: -An order, dated 4/2/24, resident is at risk for malnutrition related to COPD, diabetes, chronic pain, depression, HTN, and HLD. Registered dietician to evaluate as needed, weights as needed, labs as needed, and medications as ordered; -An order, dated 4/9/24, Does the resident experience shortness of breath while lying flat or avoids lying flat (utilizes pillows) due to shortness of breath? Every shift for COPD; -No physician's orders for use of C-PAP; -No physician's orders for use of oxygen therapy. Review of the resident's MAR, dated July 2024, showed: (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	-Does the resident experience shortness of breath while lying flat or avoids lying flat (utilizes pillows) due to shortness of breath? Every shift for COPD, showed: -On 7/1, 7/5, and 7/7/24 during the day shift, staff documented yes; -On 7/1 and 7/7/24 during the evening shift, showed no shortness of breath; -On 7/2, 7/6, and 7/7/24 during the night shift, staff documented yes. Review of the resident's progress notes, showed: -On 6/14/24 at 6:32 A.M., resting in bed. No signs of acute distress noted. Remains on increased observation after readmission. Breathing even and unlabored with C-PAP on. Activities of Daily Living (ADLs) performed by staff. No concerns or complaints voiced; -On 7/3/24 at 2:09 A.M., resident resting quietly in bed. Leg thrown over side. Resident is not wearing C-PAP mask. Encouraged to do so. Review of the resident's nurse practitioner notes, showed on 7/5/24 at 5:39 P.M., patient needs new tubing for C-PAP machine. During observation and interview on 7/08/24 at 9:39 A.M., the resident was in room with the oxygen machine turned on and set at 3 liters (L) per nasal cannula. The tubing was on the floor. The resident had a C-PAP machine on his/her night table. The mask was uncovered. Observation 7/08/24 at 4:56 P.M., and 7/9/24 at 8:00 A.M., showed the resident was in the hospital. The oxygen machine in the room remained on at 3 L. The oxygen tubing was on the floor. The C-PAP mask was uncovered on the night table. During an interview on 7/15/24 at 2:53 P.M., Restorative Aide W said to his/her understanding, the resident only used oxygen at night. During an interview on 7/15/24 at 3:00 P.M., LPN SS said the resident used oxygen, but it was only as needed. During an interview on 7/15/24 at 3:27 P.M., LPN S said the resident did not use oxygen. His/Her C-PAP was broken. The cord broke on Sunday evening, on 7/7/24, the day before the resident went to the hospital. Observation of the cord showed a tear, approximately half an inch. There should be orders for use of C-PAP and the settings. 4. During an interview on 7/16/24 at 11:18 A.M., the DON said she would expect there to be an order for use of C-PAP machine. If resident was admitted with C-PAP, she would expect nursing to notify the physician to obtain orders. The settings and diagnosis for use of C-PAP should be documented on the orders. If the resident's C-PAP was broken, Central Supply could be an option for obtaining another tube. She would expect staff to have notified the physician for the use of oxygen therapy and document it in the medical record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35394 37672 40290 42795 Based on interview and record review, the facility failed to ensure sufficient number of staff to meet the residents' needs. In addition, the facility failed to provide wound treatments for two residents (Resident #89 and #2) due to lack of nursing staff. The sample size was 30. The census was 151. Review of the facility's Staffing, Scheduling and Posting policy, revised 10/24/22, showed: -Purpose: To ensure an adequate number of nursing personnel are available to meet resident needs; -Procedure: -The facility will employ sufficient Nursing Staff on an 24 hour basis that meet the appropriate competencies, skill set, and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident; -In staffing an adequate number of nursing service personnel, scheduling will be done as needed to meet resident needs and will account for the number, acuity and diagnoses the facilities resident populations; -Nursing stations will be staffed with nursing personnel when residents are housed in the nursing unit; -The facility will employ sufficient nursing staff as determined by resident assessments and individual plans of care; -Nursing staffing will take into account the number, acuity, and diagnosis of the facility's resident population. -The DON and the Administrator will establish nursing hours and make adjustments to meet resident needs; -The shift times are established and posted in the scheduling office and in the areas convenient for nursing staff to view; -Shift times may be adjusted according to the needs of the facility with advance notice; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing staff may be added to the schedule as required by facility occupancy and workload. Review of the facility's assessment, dated 12/13/23, showed: -Average daily census: 125-135; (current census was 151) -Residents who required assistance of one to two staff persons for activities of daily living (ADL): Dressing: 76; Bathing: 42; Transfers: 66; Eating: 73; and Toileting: 68; -Residents who are dependent on staff for ADLs: Dressing: Six; Bathing: 44; Transfers: 14; Eating: Two; Toileting: 15. 1. Review of Resident #89's medical record, showed: -Diagnoses included cellulitis (deep inflammation of the tissues just under the skin) of unspecified part of limb, history of diabetic foot ulcer, acute hematogenous osteomyelitis (infection of the bone and bone marrow) multiple sites, panniculitis (inflammation of the subcutaneous fat); -An order, dated 5/7/24, for wound to right foot: Cleanse with Vashe (wound cleanser), pat dry, apply Santyl (ointment used to remove damaged tissue) nickel thick edge to edge of wound bed, cover with calcium alginate (provides a moist environment for wound healing) cut to fit, cover with bordered gauze, every day shift; -An order, dated 5/7/24, for wound to groin: Cleanse with Vashe, pat dry, apply Santyl nickel thick edge to edge to wound bed, cover with calcium alginate cut to fit, cover with ABD (absorbent abdominal) pad, every day shift; -An order, dated 6/1/24, for wound to sternum (long, flat bone of the chest): Cleanse with wound cleanser, pat dry, apply bordered gauze, every day shift; -An order, dated 6/30/24, for wound care to abdomen midline: Cleanse with wound Vashe, pat dry then apply silicone bordered gauze, every day shift for wound treatment; -An order, dated 6/30/24, for wound care to left heel: Cleanse back of left heel with Vashe, pat dry, apply Santyl to wound bed only, apply calcium alginate to wound bed only, then cover with border gauze dressing, every day shift for wound care management; -On 7/2/24, Licensed Practical Nurse (LPN) L documented unable to carry out wound treatments for right foot, groin, sternum, abdomen, and left heel, physically impossible related to nurse to patient ratio. 2. Review of Resident #2's medical record, showed: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included other specified disorders of skin and subcutaneous tissue, pressure ulcer of sacral (above the tailbone) region-unstageable (slough (dead tissue) is present, the actual base and condition of the ulcer cannot be determined), other acute osteomyelitis, osteomyelitis of vertebra, sacral and sacrococcygeal (sacral and tailbone) region, pressure ulcer of unspecified site - Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dead tissue) may be present on some parts of the wound bed. Often includes undermining or tunneling), local infection of the skin and subcutaneous tissue, sepsis (presence of bacteria and infectious organisms in the blood stream), and methicillin resistant staphylococcus aureus (MRSA, a bacterium that causes infections in different parts of the body) infection; -An order, dated 6/9/24, for Santyl ointment 250 units/gram, apply topically every day shift for wound care; -An order, dated 6/9/24, for wound to left calcaneus (heel bone): Cleanse with Vashe, pat dry, apply Santyl nickel thick edge to edge, cover with calcium alginate cut to fit, cover with ABD, wrap with kerlix (gauze bandage roll), secure with tape, every day shift for wound care; -An order, dated 6/9/24, for wound to left foot sole distal: Cleanse with Vashe, pat dry, apply Santyl nickel thick edge to edge, cover with calcium alginate cut to fit, cover with ABD, wrap with kerlix, secure with tape, every day shift for wound care; -An order, dated 6/9/24, for wound to left posterior calcaneus: Paint with betadine (topical antiseptic), cover with ABD pad, wrap with kerlix, secure with tape, every day shift for wound care; -An order, dated 6/9/24, for wound to right calcaneus: Paint with betadine, cover with ABD pad, wrap with kerlix, secure with tape, every day shift for wound care; -An order, dated 6/28/24, for wound to coccyx (tailbone): cleanse with Vashe, pat dry, apply Santyl nickel thick edge to edge of wound bed, alginate cut to fit cover super absorbent square, ABD pad, then kerlix, every day shift for wound care; -An order, dated 6/28/24, for wound to left calf: Vashe, pat dry, cover with calcium alginate cut to fit, cover bordered gauze, every day shift; -On 7/2/24, LPN L documented unable to carry out wound treatments for left calcaneus, left foot sole, left posterior calcaneus, right calcaneus, coccyx, and left calf, physically impossible related to nurse to patient ratio. (continued on next page)

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	265585	A. Building B. Wing	07/16/2024

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/10/24 at 9:05 A.M., LPN L said he/she usually works on the third floor. The facility does not have enough staff. He/She was usually the only nurse on the floor. When he/she works on the first floor, he/she is usually the only nurse working on that floor. The first floor needs at least two nurses. He/She gets pulled to work on the first floor about four to five times a month. He/She usually cannot get his/her tasks completed. When there are not enough aides, residents usually don't get their showers. The staffing ratio is not safe. One nurse working with 73 residents is not safe for the residents due to things like increased falls and wound treatments not being done. Wounds have not been cared for. The wound nurse has not been consistent with wound care. On the days he/she documented treatments as not being done, the wound nurse was not working or did not get the treatment done. He/She tells the Assistant Director of Nurses (ADON) and Director of Nurses (DON) when he/she cannot get his/her tasks done. During an interview on 7/11/24 at 9:23 A.M., the wound care plus nurse practitioner (NP) said she expected staff to administer wound care orders as written. She had educated staff multiple times of the importance of completing wound treatments. She had been told by several staff that wound treatments had not been completed related to poor staffing of nurses. She had changed multiple resident wound dressings that had been heavily soiled from feces or urine. Review of the facility's staffing sheets, dated 6/1 through 7/9/24 showed no RN coverage for the following dates: -6/1, 6/2, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/29, 6/30, 7/6, and 7/7/24. 3. During an interview on 7/9/24 at 1:46 P.M., LPN A said there are times when he/she feels the facility is short-handed. When staffing is short, he/she has to prioritize his/her workload and he/she tries to get his/her assessments done first. Sometimes there is only one nurse working on the first floor and that is not enough. When a call-off occurs, the Staffing Coordinator tries to use agency to fill in the slots. During an interview on 7/10/24 at 7:02 A.M., LPN J said that there was an instance about two months ago when he/she had to cover both units on the floor plus pass medications due to call-ins. He/She focused on the medications and did not have the time to complete the wound treatments for both units. He/She was unable to recall if the omitted treatments were reported to the oncoming nurse. He/She said that staffing has been challenging over the last few months. During an interview on 7/15/24 at 6:36 A.M., LPN II said he/she works night shift. The first floor has a higher level of care for medical needs. On night shift, the first floor requires at least one nurse and three Certified Nurse Aides (CNA)s, but ideally, four CNAs. The second floor requires a nurse and at least two CNAs, but ideally, three CNAs. The third floor needs two nurses or a nurse and a Certified Medication Technician (CMT), as well as one CNA on each side. These are the minimum staffing needs that he/she believes would be helpful on night shift. During an interview on 7/15/24 at 7:06 A.M., CNA E said he/she works day shift on the second floor, a memory care unit. He/She came in early for his/her shift today. He/She comes in early a lot because the facility can be short-handed on nights. The residents on the memory care unit need staff's help with getting cleaned up, changed, and dressed. He/She comes in early to make sure these residents are taken care of, even if staff is shorthanded. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/15/24 at 11:17 A.M., CMT K said he/she does not feel like the facility has enough staff working across all shifts. He/She gets pulled from passing medications frequently to help the CNAs and is not able to get his/her work done in a timely manner as a result. During an interview on 7/15/24 at 11:28 A.M. and 2:53 P.M., Restorative Aide (RA) W said she was hired as the facility's RA in September 2023. As the RA, she is responsible for obtaining a full set of vital signs on every resident, approximately 140 people, in the beginning of the month. She is also responsible for obtaining weights on every resident at the beginning of the month. There is no restorative program because she keeps getting pulled to work the floor because the facility is short-staffed. The facility needs to hire another RA so if staffing is short, one RA could be pulled to assist on the floor and the other RA could carry out the restorative program. They do not have enough aides. They need five aides total, that also includes one for showers, and then he/she would be able to focus on restorative. During an interview on 7/15/24 at 2:48 P.M., CNA R said he/she usually works evening shift on the second floor, a memory care unit. On the evening shift, it would be best to have three CNAs working. The residents on the second floor have more confusion in the evening. The residents need to be helped with eating dinner, going to the bathroom, getting bathed, getting changed, and getting ready for bed. The residents also wander and need to be supervised and redirected from the doors and other rooms. Showers are scheduled for day and evening shift. The facility is short-staffed at times. When staffing is short, showers do not get done. During an interview on 7/16/24 at 7:06 A.M., CNA EE said the facility is short on staff, especially on nights. He/She often works double shifts to help make sure the shifts are covered. Sometimes showers don't get done because the facility is short staffed. The facility needs another RA. There is only one RA for all the residents and it is not possible to get restorative done. During an interview on 7/16/24 at 7:00 A.M., CNA DD said the facility is short on staff. Because the facility is short on staff, he/she sometimes has to work seven days in a row to help out. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/15/24 at 3:08 P.M., the Staffing Coordinator said she is the only Staffing Coordinator for the facility. She works during the week and she is also the only person to contact when there are call-offs on the evenings and weekends. The facility's first floor requires a higher level of care. The first floor needs at least one nurse, but preferably two nurses, three CMTs, and at least four CNAs to work on the day and evening shifts. One nurse and at least three CNAs, preferably four or five CNAs, are needed on night shift for the first floor. The facility's second floor is a locked memory care unit. The second floor needs at least one nurse, one CMT, and two CNAs to work the day and evening shifts. One nurse and one CNA can cover the night shift on the second floor. The facility's third floor is behavioral, and is split into two sections, South and Main. Third floor Main needs one nurse, two CMTs, and two CNAs for day and evening shift. Third floor Main needs one nurse and one CNA for night shift. Third Floor South needs one nurse, one CMT, and at least one CNA, but preferably two CNAs, for day and evening shifts. Third floor South needs one nurse or one CMT, and one CNA for night shift. The third floor usually has three nurses so if one of the nurses gets pulled down to the first or second floor, the remaining nurse on the third floor can cover the South and Main sections. The facility does not employ enough staff to fill the schedule and they are currently hiring. The facility is currently using one agency to fill in slots where needed. The facility is a union building and if staff do not show up for their shift, they have two hours before it is officially considered a no-show, and their shift can be filled by facility staff, or can be posted on the needs list to be filled by agency. Sometimes, there is just not enough staff working. During an interview on 7/10/24 at 9:36 A.M., the DON said the first floor requires one nurse, preferably two nurses, and three CMTs for day and evening shifts. The second floor requires one nurse and one CMT for day, evening, and night shift. The third floor is split into South and Main sections. Third floor South requires one nurse and two CMTs for day, evening, and night shift, and third floor Main requires one nurse and one CMT for day, evening and night shift. When someone calls off, staff can stay over to fill in, or agency staff can be called. The Staffing Coordinator fills in shifts when needed, and the DON and two ADONs are on call to help as well. The facility has enough staff in numbers, but there is no consistency in implementing systems to ensure tasks are getting done how they should be getting done. If staff have expressed they feel there is not enough staff working, they have not discussed it with her or the Staffing Coordinator, so she does not know how to address these issues if she is not made aware of them. During an interview with the DON and Administrator on 7/16/24 at 11:17 A.M., the Administrator said the Administrator, Regional Nurse, and Regional Director of Operations are responsible for determining the staffing pattern. The staffing pattern is determined by the census number and fire code needs. The staffing pattern is communicated to the Staffing Coordinator, who is responsible for filling in shifts accordingly. The Staffing Coordinator has the staffing phone on her 24 hours a day, 7 days a week. If she needs time off, there is someone else who can fill in for her. The facility currently uses one contracted agency to assist in filling shifts. The facility is currently hiring. If there is a call-off, the Staffing Coordinator contacts as needed (PRN) facility staff first to see if they can pick up a shift. Part-time staff are also contacted to see if they are available. If one floor has more than enough staff, they will move people to help where needed. All departments and department heads are able to pitch in and help where needed. Anyone certified in an area can assist in that area when the facility is shorthanded. The interdisciplinary team (IDT) has had conversations about staffing shortages. Retention has been an issue at the facility. MO00230468 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO00230563 MO00233204 MO00235070 MO00235408 MO00237997 46888 49992

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42795 Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. The census was 151. Review of the facility's Nursing Department, Staffing, Scheduling, and Postings policy, revised 10/24/22, showed the facility must use the services of an RN for at least eight consecutive hours a day, seven days a week, unless a waiver applies. Review of the facility's staffing sheets, dated 6/1 through 7/9/24 showed no RN coverage for the following dates: -6/1, 6/2, 6/15, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/22, 6/23, 6/29, 6/30, 7/6, and 7/7/24; During an interview on 7/10/24 at approximately 12:00 P.M., the Staffing Coordinator said the facility currently has one as needed (PRN) RN but can utilize agency staff to cover the RN vacancy on the schedule. During an interview on 7/16/24 at 11:16 A.M., the Administrator said she expected the Staffing Coordinator to schedule RN coverage eight hours a day, seven days a week. The facility is actively recruiting for RNs online and have sign on and referral bonuses in place. RNs are difficult to recruit. MO00230468 MO00230563 MO00233204

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42795 Based on observation, interview and record review, the facility failed to post the nurse staffing information daily in a prominent place, readily accessible to residents and visitors. In addition, the daily staffing sheets maintained by the facility did not include the facility name. The census was 151. Review of the facility's Nursing Department Staffing, Scheduling, and Postings policy, revised 10/24/22, showed: -Posting requirement: -The facility will post the following information on a daily basis: -Facility name; -The current date; -The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift; -Facility census; -The facility will post the nurse staffing data specified above, on a [NAME] basis at the beginning of each shift; -Data must be posted in a clear and readable format and in a prominent place readily accessible to residents and visitors. Review of the daily staffing sheets dated 6/3 through 7/9/24 showed: -On 6/1, 6/2, 6/8, 6/9, 6/15, 6/16, 6/19, 6/29, 6/30, 7/4, 7/5, 7/6, and 7/7/24, the sheets were not completed and posted. -On 6/3, 6/4, 6/5, 6/6, 6/7, 6/10, 6/11, 6/12, 6/13, 6/14, 6/17, 6/18, 6/20, 6/21, 6/24, 6/25, 6/27, 6/28, 7/1, 7/2, 7/3, 7/8, and 7/9/24, the sheets did not have the facility name listed. Observation on 7/9/24 at approximately 12:00 P.M., showed the daily staffing sheet posted at the facility's front desk without the facility name listed. During an interview on 7/10/24 at approximately 12:00 P.M., the Staffing Coordinator said she is the only staff person that fills out the staff sheets and posts them. The sheets have not been filled out or posted on the days that she is not working. She was not aware that the sheets needed to be filled out and posted daily with the facility name. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 7/16/24 at 11:16 A.M., the Administrator said she would expect the staffing sheets to be filled out correctly and posted on a daily basis in a prominent area.

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49992 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident #93), diagnosed as having dementia with depression and exhibiting symptoms/behaviors, received the appropriate treatment and services to attain or maintain his/her highest practicable physical, mental and psychosocial well-being. The facility failed to follow the recommendations from his/her psychiatric Nurse Practitioner (NP) and there was no Social Service documentation of the resident's behaviors and individualized interventions provided by Social Services. The census was 151. Review of the facility's policy titled, Physician Orders, revised 10/24/22, showed: -Purpose: This will ensure that all physician orders are complete and accurate; -Other orders will include a description complete enough to ensure clarity of the physician's plan of care; -Documentation pertaining to physician orders will be maintained in the resident's medical record. Review of Resident #93's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/15/24, showed: -admitted [DATE]; -Moderate cognitive impairment; -Moderate depression; -Set-up for eating, oral hygiene, and toileting. Supervision for showers; -Diagnoses include high blood pressure, diabetes, high cholesterol, Alzheimer's and depression. Review of the resident's care plan, dated 7/28/23, showed: -Focus: Resident has impaired cognitive function related to dementia; -Goal: Resident will be able to communicate basic needs on a daily basis through the review date; -Interventions: Ask simple yes/no questions in order to determine resident's needs. Cue, reorient and supervise as needed. Review of the resident's clinical Visit-Mental Status Exam (MSE), showed the following: -September 18, 2023, to start donepezil (cognition-enhancing medication) 5 milligrams (mg) daily at nighttime. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician Orders, showed the recommendation for donepezil was not transcribed. Review of the resident's medical record, showed no Social Service notes related to resident behaviors. Review of the resident's care plan, dated 12/15/2023, showed: -Focus: Resident uses antidepressant medication related to depression, poor adjustment to admission, and poor nutrition; -Goal: Resident will be free from discomfort or adverse reactions related to antidepressant therapy; -Interventions: Administer antidepressant medications as order by physician. Monitor/document side effects and effectiveness. Monitor/document/report as needed adverse reactions antidepressants therapy. Review of the resident's clinical Visit MSE, showed the following: -August 23, 2024, to add Namenda XR (cognition-enhancing medication) 7 mg daily for Alzheimer's. Review of the resident's Physician Orders showed the recommendation for Namenda XR was not transcribed. Observation on 7/8/24 at 9:30 A.M., showed the resident at the nurse's station, crying and staff re-directing him/her. Staff walked down the hall with the resident, consoling and attempting to redirect the resident. The resident came out of his/her room crying and said, I just don't understand. Observation on 7/9/2024 at 8:00 A.M., showed the resident sat in the dining room, very tearful, making statements he/she wanted to leave with his/her daughters. Observation on 7/10/24 at 1:21 P.M., showed resident near the locked doors on the unit crying, talking very loudly, and appeared to be upset with daughters. Observation on 7/11/24 at 9:07 A.M., showed the resident at the nurse's station crying, wanting the use the phone to call his/her daughter. Observation on 7/12/24 at 9:41 A.M., showed the resident on the phone at the nurse's station, saying he/she wanted to leave. The resident was tearful. During an interview on 7/8/24 10:03 A.M., Licensed Practical Nurse (LPN) D said the resident had frequent crying episodes. The resident can be redirected sometimes. During an interview on 7/11/24 at 10:58 A.M., LPN J said he/she did not know where to locate the psychiatric NP notes. LPN J was aware there is a new order for a medication. He/She is unaware of where the medication orders originate and never sees the visit notes. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 11:05 A.M., LPN D said he/she was unaware of a new physician order until there was an instance when he/she had to call to the pharmacy to clarify a medication that was ordered by the psychiatric NP. He/She spoke with another nurse regarding the order for the medication. He/She was informed the psychiatric NP emails the recommendations to the Director of Nursing (DON) and then transcribes the order into the electronic medical record. During an interview on 7/16/24 at 12:30 P.M., the Administrator there had been a break down in the process with the psychiatric recommendations. Prior to May 2024, the recommendations were sent to the DON, who would send the recommendations to the Unit Managers, who would transcribe the orders into the electronic medical record. At this time, the psychiatric recommendations are only available if requested by the staff and she is unaware if there are any current recommendations. During an interview on 7/16/24 at 12:30 P.M., the DON said the resident may not have experienced the ongoing behaviors, crying, and pacing if the medications would have been administered.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35394 37672 Based on interview and record review, the facility failed to keep one resident with epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures) free from a significant medication error, when the facility failed to administer the ordered Keppra (used to prevent seizures). The resident experienced a grand mal seizure (a tonic-clonic seizure, causing the loss of consciousness and violent muscle contractures) with fall at the facility and he/she sustained a fracture of the right proximal fibular shaft (lower leg outer bone) (Resident #14). In addition, staff administered Ambien (a sedative) to Resident #69, for which he/she had a known medication allergy. The census was 151. The Administrator was notified on 7/12/24 at 12:45 P.M., of an immediate jeopardy (IJ) which began on 4/17/24. The IJ was removed on 7/12/24 as confirmed by surveyor on-site verification. Review of the Medication Administration Policy, revised 10/24/22, showed: -Purpose: to provide practice standards for safe administration of medication for residents in the facility; -Policy: -Medication will be administered by a licensed nurse per the order of an attending physician or licensed practitioner; -Medications must be given to the resident by the licensed nurse preparing the medication or as consistent with state law; -Medications are not to be left at bedside; -Documentation: -The time and dose of the drug or treatment administered to the resident will be recorded in the medication record by the person who administered the drug or treatment; -The recording will include the date, the time and dosage of the medication or type of the treatment. 1. Review of Resident #14's medical record, showed: -admitted : 6/18/20. -discharged to hospital: 4/17/24; -readmitted : 4/21/24; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included: Fracture of the right fibula (readmitted with), epilepsy, intellectual disability, dementia, schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly) and anxiety. Review of the electronic physician order sheet (ePOS), showed an order, dated 3/4/24: Keppra (levetiracetam) oral solution 100 milligrams (mg)/milliliter (ml). Give 20 ml by mouth twice a day related to convulsions. Review of the pharmacy shipping manifest, dated 4/13/24 at 4:27 P.M., showed Levetiracetam 100 mg/ml solution delivered to the facility. Review of the April 2024 medication administration record (MAR), showed: -An order, dated 3/4/23: Keppra oral solution 100 mg/ml. Give 20 ml twice a day related to unspecified convulsions. Scheduled daily at 9:00 A.M. and 5:00 P.M. -On 4/16/24: -At 9:00 A.M., documented as given; -At 5:00 P.M., documented as 9 or see progress notes. Review of the progress notes, showed: -On 4/16/24 at 5:15 P.M.: give Keppra 100 mg/ml, give 20 ml twice a day. Not available, on order. Review of the April 2024 MAR, showed: -On 4/17/24: -At 9:00 A.M., documented as given; -At 5:00 P.M., documented at 9 or see progress notes. Review of the progress notes, showed: -On 4/17/24 at 5:30 P.M., Keppra 100 mg/ml, give 20 ml twice a day. Not available; -On 4/17/24 at 11:49 P.M., staff notified of the resident lying face down on the bathroom floor seizing, halfway in the bathroom and in the hallway, saturated with urine. Observed in a grand mal seizure, lasted approximately 3-4 minutes. He/She continued to lie on the floor making a snoring sound, difficult to rouse. The physician was notified and new orders to send to the emergency room (ER) for evaluation and treatment. Review of the ER history and physical, dated 4/18/24 at 2:24 P.M., showed: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Briefly admitted for breakthrough seizure. Corroborating information helped us determine the patient was likely not receiving daily Keppra due to the facility running out of medication. He/She was found to have a right lower extremity fibular fracture. The patient was seen by Orthopedics and placed in an air boot with weight bearing as tolerated allowances; -Subjective: Per Emergency Medical Services (EMS) report and patient, the facility had apparently ran out of the prescribed liquid Keppra, and he/she had not been taking it for an unclear period of time. Per EMS it was around three days, and per patient, he/she had not received it in over two weeks. He/She arrived to the ER, was lethargic and post-ictal (altered state of consciousness after an epileptic seizure) state, he/she received a Keppra load of 4500 mg and alertness improved over time, and no seizure activity was noted. The patient stated, he/she did not receive the prescribed liquid Keppra as the facility ran out and were unable to obtain refills. On chart review the patient had to prior ED visits due to seizures, with similar presentation in which the facility ran out of Keppra. He/She was discharged with liquid Keppra at that time and Keppra levels at those times were low and corresponded with a lack of adherence. The facility was contacted and staff reported no supply issue with Keppra; -Assessment and plan: -History of epilepsy: patient has longstanding history of epilepsy, previous neurology note, showed the patient is supposed to be on liquid Keppra. Appears to be provoked in setting of Keppra nonadherence per discussion with EMS and patient. Since arrival at the ED, no further seizures; -Plan: Keppra and carbamazepine (used to treat seizure disorders) levels ordered. Carbamazepine level normal, awaiting Keppra level. Review of the hospital emergency physician note, dated 4/19/24 at 3:07 A.M., showed: -History of present illness: history of intellectual disability, convulsion disorder, epilepsy and anxiety. To ER for witnessed seizure lasting several minutes. Per EMS, the facility has been out of liquid Keppra for an unknown amount of time. Complaint of pain in the right leg; -Physical exam: -Head, ear, nose and throat (HENT): hematoma (an area of pooled blood) to the left outer eyebrow; -Decision making: -Diagnoses: fall, seizure like activity, hematoma to the left eyebrow and right sided leg pain; -Plan: therapeutic Keppra load, imaging of right leg and facial bone; -Emergency Department (ED) course: -At 1:23 A.M.: 4,500 mg of Keppra given in fluids; -At 1:53 A.M.: 4,500 mg of Keppra administration was stopped; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 3:50 A.M.: Orthopedics consulted; -At 4:15 A.M.: reviewed imaging, the patient has a right fibular fracture. Facial imaging is negative; -At 5:42 A.M.: patient will be admitted for management of seizure-like activity. Review of the hospital levetiracetam level, resulted 4/20/24 at 2:12 A.M., showed: -Levetiracetam level: value: below 2; -Reference range: 10-40 microgram/milliliter (ug/mL); -Flag: low (L). Review of the hospital neurology progress note, dated 4/20/24 at 7:28 A.M., showed: -Subjective: Levetiracetam level came back undetectable from admission labs, this essentially definitively shows etiology of seizure medication nonadherence; -Hospital course: Per EMS and family, the facility ran out of Keppra and the resident had not taken the medication for three days, per the patient, it has been two weeks. When the hospital primary team called the facility, it was stated the facility did not have issues with medication supply. On previous admissions July 2023 post seizure, it was determined to have Keppra non-adherence at those times; -Recommendations: -Keppra level undetectable which strongly suggests non-adherence to prescribed Keppra regimen; -Resuming antiseizure regimen will likely resolve episode as this was an effective regimen in the past. Review of the hospital discharge summary, dated 4/20/24 at 12:23 P.M., showed: -Hospital course: Neurology was consulted for the seizures and determined to be related to missed doses of Keppra. In discussions with the family and the facility, it was confirmed he/she missed two doses of the Keppra. Keppra level at the hospital came back low, confirming the missed doses. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 7/12/24 at 10:11 A.M., CMT XX said that he/she attempted to give the resident his/her ordered Keppra, but it was not available on the cart around 4/16/24. The resident was getting the liquid form of Keppra. He/She reported to an unknown nurse the resident was out of the medication. He/She was off the next day. When he/she returned the following day, he/she noted the medication was still not available. The staff from the day before had documented on the MAR the medication was given. He/She called the pharmacy, and the pharmacy said the medication was not sent. He/She told the nurse, who was working on a different floor, about the Keppra not being available and to get the medication from the e-kit. He/She called the pharmacy, told them the medication was not available and was not delivered. The pharmacy stated the medication would be delivered the evening of 4/17/24. When the charge nurse returned to the floor, the resident was experiencing a seizure. Management conducted an investigation, and he/she was in-serviced on 4/18/24. During an interview on 7/9/24 at 10:59 A.M., the former regional nurse, said the facility was notified by the hospital physician regarding the Keppra level was low and not measurable. The facility conducted an investigation and discovered the resident did not receive two to three doses of ordered Keppra. The facility conducted in-servicing immediately. Review of the facility in-services regarding medication administration, dated 4/18/24 through 5/29/24, following the resident's seizure and hospitalization , showed nine of 19 currently employed Licensed Practical Nurses (LPN) were in-serviced. No current employed graduate nurses (GN) were in-serviced and one currently employed Registered Nurse (RN) was not in-serviced. During an interview on 7/9/24 at 11:11 A.M., the Minimum Data Set (MDS) Coordinator said he/she assisted management with in-servicing on missed medication, medications not available and expectations on what staff should do if medications are not available. In-servicing was done for a month. New staff had been hired at the facility. She is unaware if the new staff had been in-serviced. During an interview on 7/10/24 at 6:30 A.M., LPN GG said he/she works night shift. There is no Certified Medication Technician (CMT) on night shift. The nurses administer medications as needed on night shift. If a medication was not on the medication cart, he/she would double check the cart, check the emergency kit (e-kit, supply of emergency stock medications), and contact the pharmacy. He/She has never used the e-kit and he/she is unsure what medications it contains. If the medication cannot be administered, he/she would notify the resident's responsible party and physician. On the MAR, he/she would document other, see progress notes, and he/she would make a note as to why the medication was not administered. During an interview on 7/11/24 at 11:47 A.M., Graduate Practical Nurse (GPN) FF said if he/she could not find a resident's medication on the medication cart, he/she would check the storage room. If he/she could not locate the medication in the storage room, he/she would order the medication from the pharmacy. If the pharmacy could not deliver the medication the nurse needed to notify the DON and access the e-kit for the medication. He/She has not had any training on e-kits. He/She does not have access to an e-kit and does not know what an e-kit is. He/She asked if an e-kit is where narcotic medications are stored. During an interview on 7/11/24 at 12:06 P.M., LPN HH said CMTs and nurses are responsible for medication administration. If a medication is not on the cart, staff should check the storage room, call the pharmacy, and call the doctor. Staff could pull the medication from the e-kit, if possible. He/She does not have access to the facility's e-kits. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a interview on 7/9/24 at 10:26 A.M., the nurse practitioner said, Keppra is an important medication used to prevent the occurrence of seizures. If Keppra doses are missed, the resident could experience a seizure. If Keppra is missed, the medical provider should be notified. 2. Review of Resident #69's resident's hospital record, showed: -Admission: 9/27/23; -Discharge: 11/6/23; -Known allergies: Xanax (sedative), Ziprasidone (antipsychotic), Seroquel (antipsychotic), Geodon (antipsychotic), Ambien (sedative), Wellbutrin (antidepressant), and Venlafaxine (antidepressant). Review of the resident's quarterly MDS, a federally mandated assessment instrument completed by facility staff, dated 5/10/24, showed: -Mild cognitive impairment; -No behaviors; -Diagnoses included high blood pressure, wound infection, septicemia (blood infection), hip fracture, anxiety, depression; -Administered anti-depressant, hypnotic, anticoagulant, opioids in the past seven days; -Drug regimen review: Yes, issues found during review. Review of the medical record, showed: -admitted [DATE]; -Allergies: Flu Virus Vaccine, Venlafaxine, Ambien, Geodon, Wellbutrin, Xanax; -An order, dated 5/30/24, Ambien Oral Tablet 5 mg. Give 5 mg by mouth every 24 hours as needed for insomnia for 30 Days. Order was discontinued on 6/11/24; -The June 2024 MAR, showed Ambien oral tablet 5 mg. Give 0.5 (half) tablet by mouth every 24 hours as needed for insomnia was administered on 6/30/24. Review of the care plan, in use during survey, showed: -Focus: Resident is on sedative/hypnotic therapy related to insomnia; -Goal: Will be free of any discomfort or adverse side effects of hypnotic use; -Interventions: On 4/2/2024: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Nurse Practitioner (NP) has provided education to resident regarding his/her sleeping habits. Encouraged to avoid caffeine after lunch and all alcohol; -Administer sedative/hypnotic medications as ordered by physician; -Evaluate other factors potentially causing insomnia, for example: environment (excessive heat, cold, or noise), lighting, inadequate physical activity, facility routines, caffeine/medications. Attempt to modify and control these external factors before initiating hypnotic therapy; -Monitor/Document/Report as needed (PRN) for following adverse effects of Sedative/Hypnotic therapy: daytime drowsiness, confusion, loss of appetite in the morning, increased risk of falls and fractures, dizziness. Review of the resident's July 2024 ePOS, showed an order, dated 6/25/24: Ambien oral tablet 5 mg. Give 0.5 mg tablet by mouth every 24 hours as needed for insomnia. Review of the resident's July 2024 MAR, showed Ambien oral tablet 5 mg. Give 0.5 tablet by mouth every 24 hours as needed for insomnia. Noted as administered on 7/13/24 and 7/14/24. Review of the resident's progress notes, showed: -On 7/13/24 at 10:40 P.M., Ambien oral tablet 5 mg. Give 0.5 tablet my mouth every 24 hours as needed for insomnia. PRN administration was effective; -On 7/15/24 at 5:44 A.M., Ambien oral tablet 5 mg. Give 0.5 tablet my mouth every 24 hours as needed for insomnia. PRN administration was effective; -No further documentation on the resident's allergy to Ambien or symptoms after administered Ambien. Observation and interview on 7/11/24 at 10:45 A.M., showed the resident in bed, eyes closed, and he/she briefly opened them. The resident said he/she was sleeping and usually slept a lot during the day. He/She did not have trouble sleeping at night; -On 7/15/24 at 8:07 A.M., the resident lay in bed; eyes closed. -On 7/16/24 at 1:23 P.M., the resident in bed and said he/she did not have a problem sleeping during the day. He/She was told he/she had an allergy to some psychotropic medications. The surveyor named off medications from the resident's allergy list. He/She was unsure if he/she was allergic to Ambien or Xanax, and he/she was unsure what the allergy symptoms were. The resident confirmed he/she was allergic to flu shot vaccines for sure. During an interview on 7/15/24 at 10:47 A.M., LPN S said the resident was not a heavy sleeper. He/She naps a lot during the day. He/She will wake up and do whatever he/she wants, maybe smoke and then go back and nap. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/16/24 at 8:53 AM, CMT YY said staff should automatically know to check for allergies. When he/she administers medications, he/she checked the resident's name, medication name and allergy list. CMT YY said the allergy list shows in the resident's medical record at the top, and all allergies are in RED font. If the medication was ordered and listed on their allergies, he/she would report it to the nurse. During an interview on 7/16/24 at 11:18 A.M., the Director of Nurses (DON) said nursing is responsible for re-capping and ensuring orders are accurate. If there are allergies, it is in red in the medical record. It is on the profile, and staff should note any allergies. She would expect staff to contact the physician if a resident was ordered a medication that was on the allergy list. Nursing should not administer the medication and notify the physician. It should be documented if the physician was notified. The DON was not aware if an assessment was completed or what type of symptoms the resident has with use of Ambien. Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the deficiency was lowered to the D level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s). MO00234902 40290

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49992 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional standards and facility policy in two of two medication rooms and three of five medication/treatment carts. The census was 151. Review of the facility's Medication Storage Policy, dated 1/2021, showed: -Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; -Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log or tracking mechanism is maintained to verify that the temperature has remained in acceptable limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily; -Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments, and suppositories; -Outdated, contaminated, discontinued or deteriorated medications and those in container that are cracked, soiled, or without secure closures are immediately removed from the stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists; -Medication storage should be kept clean, well lit, organized and free from clutter. Review of Medline's Evencare Blood Glucose Monitoring System recommendations, showed: -Keep the test strips away from direct sunlight and heat. Store the test bottle in a dry, cool place. -For vial test strips, record the date on the bottle when opened. Discard any unused test strips six months after opening. Review of Advair Diskus 250/50 patient information, showed: -Write the date you opened the foil pouch in the first blank line on the diskus label. Write the use by date in the second blank line on the label. Discard after 30 days. Observations during the survey, showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/9/24 at 10:40 A.M., the first floor medication room locked refrigerator had boxes of medication on the lower shelf, and a bag of Tuberculin dose vials in a bag which was wet from water leaking from the freezer. The temperature was 42 degrees Fahrenheit (F); -On 7/9/24 at 11:06 A.M., the third floor medication room had an open bottle of Active Liquid Protein that expired 1/2024; -On 7/11/24 at 9:09 A.M., the second floor nurse medication cart had Nystatin Powder located in the same drawer with eye and oral medications; -On 7/11/27 at 9:27 A.M., the second floor Certified Medication Technician (CMT) cart had undated Advair Diskus inhaler, an opened bottle of Artificial Tears, dated 7/2023, and an opened stock bottle of iron, dated 4/2023, unable to read the expiration date due to fading; -On 7/11/24 at 9:45 A.M., the first floor nurse medication cart had a bottle of Evencare accu-check strips not dated and an opened bottle of Milk of Magnesium, no open date and expired March 2024; On 7/16/24 at 9:57 A.M., the first floor medication room locked refrigerator still contained the wet boxes of medication on the lower shelf, temperature was 28 degrees F, and icicles formed on the bottom side of the freezer. The temperature log did not reflect the second temperature reading on the July flow sheet. During an interview on 7/9/24 at 10:40 A.M., Certified Medication Technician (CMT) OO, said he/she was unaware water was dripping from the freezer and would notify the Charge Nurse. During an interview on 7/9/24 at 11:06 A.M., Assistant Director of Nursing (ADON) CC said expired medications should be removed from the medication room and thrown away. During an interview on 7/11/24 at 9:09 A.M., CMT F said the bottle of nystatin powder should not be in the same cart where the residents' medications are located. The powder should be stored in the nurse's treatment cart. During an interview on 7/11/24 at 9:27 A.M., CMT G said inhalers must be dated when they are removed from the box, and medications that are no longer being used or expired should be removed from the cart. During an interview on 7/11/24 at 9:45 A.M., Licensed Practical Nurse (LPN) A said accu-check bottles should be dated when opened and expired medications should be removed from the cart. During an interview on 7/15/24 at 2:35 P.M., LPN L said the refrigerators should be checked daily and the temperature recorded on the paper on the door. Items stored in the refrigerators were injectables such as insulin pens, the solution used to check for tuberculosis (TB), and vaccines. The temperature must be kept at a certain level, so medications won't go bad. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 12:30 P.M., the Director of Nursing (DON) said she expected the nurses to check the temperature of the refrigerators regularly. She was unaware that the refrigerators that contain vaccines should be checked twice daily per facility policy. If a refrigerator is unable to keep temperature and is malfunctioning, the nurses should contact maintenance and nursing management. The medication carts are checked weekly. The medications that are expired or no longer ordered for the residents should be removed from the medication rooms and carts. Inhalers, insulins, and accu-check strips should be dated when opened. The medications used for treatments should not be kept in the same cart with other the medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46888 Based on interview and record review, the facility failed to designate a person to serve as the Director of Food and Nutrition Services with the appropriate certification. This had the potential to affect all residents who consumed food prepared by the facility. The census was 151. Review of the facility's Dietary Manager job posting, undated, showed: -Job Requirements: you are certified by the Association of Nutrition and Food Service Professionals, you completed a dietary manager exam. During an interview on 7/16/24 at 9:18 A.M., the Dietary Manager said he does not currently have any certifications. He went through the course but never took the test. During an interview on 7/16/24 at 9:27 A.M., the Administrator said the Registered Dietician comes to the facility on ce a week and is not employed full-time with the facility. She said the Dietary Manager was hired on 9/29/22 and does not have the appropriate certification at this time. She expected the Dietary Manager to have the required certifications.

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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** 46888 Based on observation, interview and record review, the facility failed to provide residents food at a safe and appetizing temperature for three residents (Residents #30, #58, and #111). The sample was 30. The census was 151. Review of the facility's food temperatures policy, revised 10/24/22, showed: -Purpose: To provide the dietary department with guidelines for food preparation and service temperatures; -Policy: Foods prepared and served in the facility will be served at proper temperatures to ensure food safety; -Acceptable serving temperatures: Eggs should be greater than 135 degrees Fahrenheit (F), meat entrees should be greater than 135 degrees F, cereal or oatmeal should be 135 degrees F. 1. Review of Resident #30's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/12/24, showed: -Cognitively Intact. During an interview on 7/8/24 at 9:14 A.M., the resident said his/her food was cold most of the time when it was delivered to his/her room. 2. Review of Resident #58's quarterly MDS, dated [DATE], showed: -Moderately impaired cognition. Observation during the survey, showed the resident resided on the second floor. During an interview on 7/8/24 at 11:07 A.M., the resident said his/her food was normally delivered to him/her cold. 3. Review of Resident #111's quarterly MDS, dated [DATE], showed: -Cognitively intact. During an interview on 7/8/24 at 9:00 A.M., the resident said his/her food was almost always cold by the time it was delivered to his/her room. 4. Observation on 7/11/24 at 11:42 A.M., of lunch trays served on the second floor, showed the following temperatures: -Waffle measured at 76.8 degrees F and was cold; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hash browns measured at 94.4 degrees F and were cold; -Fried chicken measured at 103 degrees F and was cold. Observation on 7/15/24 at 7:58 A.M., of breakfast trays served on the second floor, showed: -Sausage patty measured at 85 degrees F and was cold; -Eggs measured at 83 degrees F and were cold; -Oatmeal measured at 110 degrees F and was lukewarm. 6. During an interview on 7/15/24 at 9:44 A.M., [NAME] Q said he/she expected food to be delivered to the residents at the appropriate temperatures. He/She said this was important to ensure the residents received a hot meal. During an interview on 7/15/24 at 9:47 A.M., the Dietary Manager said he expected residents to receive their food at the required temperatures to avoid illness. During an interview on 7/15/24 at 2:56 P.M., the Administrator said she expected food to be delivered at the appropriate temperatures. 49992

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to ensure two residents received mechanically altered diets in accordance with physician orders (Residents #127 and #15). The census was 151. Review of the facility's Therapeutic Diets policy, revised 10/24/22, showed: -Purpose: To ensure that the facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders; -Policy: Therapeutic diets are diets that deviate from the regular diet and require a physician order. Per the physician order, therapeutic diets are planned, prepared and served in consultation with the Dietitian; -Procedure: -The nursing staff is responsible for communicating the physician's order for a therapeutic diet to the dietary department in writing; -The therapeutic diet will be reflected on the resident's tray card. -The Dietary Manager will periodically review the resident's tray card and the physician's dietary orders to ensure that the information is consistent. 1. Review of Resident #127's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/22/24, showed: -Moderate cognitive impairment; -Independent with eating; -Diagnoses included malnutrition, dysphagia (difficulty swallowing), diabetes, and cognitive communication deficit; -Therapeutic diet received. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has nutritional problem or potential nutritional problem related to diet restrictions; -Interventions included: Provide and serve diet as ordered. Regular diet, mechanical soft texture. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic physician order sheet (ePOS), showed an order, dated 6/10/24, for mechanical soft texture diet. Review of the resident's diet card, undated, showed Regular diet checked at the top of the card. Observation on 7/8/24 at 4:54 P.M., showed the resident on his/her left side in bed with a plate of whole egg rolls and noodles. The resident used his/her hands to rip up the food and put it in his/her mouth, spitting bits of food out of his/her mouth while he/she chewed. During an interview, the resident said the food was good. He/She was unable to answer questions about the food texture. Observation on 7/15/24 at 11:44 A.M., showed the resident sat in the dining room with a whole hamburger and crinkle-cut fries. The resident used his/her hands to rip up the hamburger and put it in his/her mouth, spitting bits of food out while he/she chewed. During an interview on 7/15/24 at 2:48 P.M., Certified Nurse Aide (CNA) R said the resident has been spitting out his/her food while he/she eats. He/She used to receive mechanical soft food, but it was switched to regular texture a month ago and that's when he/she began spitting out his/her food. During an interview on 7/16/24 at 11:09 A.M., the Speech Therapist said the resident was referred to her in June 2024 and she completed a swallow evaluation. The resident has been having issues with swallowing. He/She has been expelling his/her food, but not always. His/Her diet was downgraded to mechanical soft because he/she does not have enough teeth. She expects the resident to receive a mechanical soft diet. If dietary serves the resident whole foods, nursing staff usually chop up the food for the resident. During an interview on 7/16/24 at 9:30 A.M., the Dietary Manager (DM) said the resident has been chewing his/her food and spitting it out. He/She is supposed to receive a mechanical diet, not a regular diet. During the interview, the DM reviewed the resident's diet card, which showed regular diet. The DM said the resident's diet card had been changed by someone else, and he did not know who. Dietary staff should not change the diet cards and should always go by physician-ordered diet. 2. Review of Resident #15's medical record, showed: -Diagnoses included malnutrition, nutritional anemia, dementia, cognitive communication deficit, and diabetes; -A physician order, dated 5/20/24, for mechanical soft diet, easy to chew. Review of the resident's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Supervision or touching assistance required for eating; -Diagnoses included malnutrition, dementia, cognitive communication deficit, stroke, heart failure, kidney failure, and high blood pressure; -Mechanically altered and therapeutic diet received; (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Signs and symptoms of possible swallowing disorder: Holding food in mouth/cheeks or residual food in mouth after meals. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident consumes a regular diet; -Interventions included: Monitor for change in appetite, inform physician and responsible party; -Focus: Resident has nutritional problem or potential nutritional problem related to anorexia - loss of appetite and unplanned weight loss; -Interventions included: Provide, serve diets as ordered, regular diet with thin liquids; -The care plan failed to identify the resident's physician order for mechanical soft diet. Review of the resident's diet card, undated, showed Mech handwritten across the card. During an interview on 7/8/24 at 9:45 A.M., the resident said he/she is missing his/her bottom dentures. Staff give him/her chopped up food to make eating easier. Observation on 7/8/24 at 4:51 P.M., showed the resident sat in the dining room with a plate of whole egg rolls and noodles. Observation on 7/15/24 at 7:42 A.M., showed the resident sat in the dining room with a whole sausage patty, biscuit, and scrambled eggs on his/her plate. Observation on 7/15/24 at 11:44 A.M., showed the resident sat in the dining room with a whole hamburger and crinkle-cut fries on his/her plate. 3. During an interview on 7/9/24 at 8:44 A.M., Licensed Practical Nurse (LPN) D said the meals served by dietary are not consistent. Sometimes residents are served whole foods when they are supposed to receive mechanical soft texture. When this happens, he/she has to go to dietary and request the correct food. Dietary and nursing staff are responsible for ensuring residents are served diets as ordered. Yesterday, whole egg rolls were served to residents who were supposed to receive mechanical soft, and he/she had to remove the egg rolls because it was not the right texture. During an interview on 7/15/24 at 2:48 P.M., CNA R said when dietary sends the meal trays up to the floor, the trays include the resident's diet card. The diet card tells staff what type of diet the resident should receive, including texture, such as mechanical-soft. When nursing staff passes the trays, they check the diet card and make sure trays have the correct foods on them. If the tray has regular texture food when it should be mechanical soft, nursing staff call the kitchen and let dietary staff know. Nursing staff can also chop up the food to make it small for the resident. It is important for residents to be served the correct texture of food to help them with chewing. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 7:40 A.M., the Wound Nurse said she expects dietary to make sure they properly set up the meal trays before the trays are brought out to the floor. Once the trays are brought out, she expects nursing staff to check the diet card to make sure the tray is correct before passing it out. If the tray is incorrect, nursing should contact dietary. Dietary staff have been sending out the wrong food textures and items, then they get mad when nursing calls them to get the right items. Residents should receive mechanical diets as ordered because they need to have the right texture to prevent choking and address issues with swallowing. During an interview on 7/15/24 at 10:01 A.M., the DM said he is made aware of changes to a resident's diet when nursing sends him a diet slip. Once he receives a diet slip, he puts the diet order on a dietary card. He expects residents to be served diets as ordered to prevent choking or other health concerns. Whole foods, such as egg rolls, are not considered mechanical texture. If dietary sends out food with the wrong texture, he expects nursing staff to report it to dietary and they will change the food. During an interview with the Director of Nurses (DON) and Administrator on 7/16/24 at 11:17 A.M., the Administrator said when trays come up to the dining room, she expects nursing staff to check the diet card before passing the trays to make sure the correct foods are served. Diet cards are created by the DM, based on the orders put in the resident's electronic medical record. If nursing staff see the food texture on a plate does not match the food texture on the diet card, they are expected to decline the tray and notify dietary to get the issue fixed. Providing residents with the proper texture of food is important to prevent aspiration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46888 Based on observation, interview, and record review, the facility failed to keep the kitchen equipment clean and floors free of dust, grease, and grime. In addition, staff failed to wear a beard net when preparing food. The census was 151. Review of the facility's weekly cleaning list, dated 1/21/24, showed: -Weekly cleaning: prep table, floors swept and mopped, cook station floors behind the fryers, walk in freezer, and fans and duct work. 1. Observation 7/8/24 of the kitchen, showed: -At 8:31 A.M., the walk-in freezer with trash and food debris on the floor in multiple areas; -At 8:34 A.M., the flour and sugar bulk bins observed to have lids caked with a white powder substance; -At 8:35 A.M., the deep fryer observed with a sticky, dried grease build-up on the sides; -At 8:35 A.M., the floor under the tilt skillet observed with a dark liquid with other debris spilled and puddled; -At 8:36 A.M., a fan in the dish washing room with a dust build-up, blowing on the clean dishes. 2. Observation 7/9/24 of the kitchen, showed: -At 10:47 A.M., a fan in the dish washing room with dust build-up, blowing on the clean dishes; -At 10:48 A.M., the walk-in freezer with trash and food debris on the floor in multiple areas; -At 10:48 A.M., the flour and sugar bulk bins observed to have lids caked with a white powder substance; -At 10:49 A.M., the deep fryer with a sticky, dried grease build-up on the sides. the floor under the tilt skillet with a dark liquid with other debris spilled and puddled. 3. Observation 7/10/24 of the kitchen, showed: -At 6:12 A.M., a fan in the dish washing room with dust build-up blowing on the clean silverware; -At 6:15 A.M., the floors in the main kitchen had various areas with food spills and food debris. The floors by the tilt skillet with a dark liquid with other debris spilled and puddled; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 6:16 A.M., the deep fryer with a sticky, dried grease build-up on the sides; -At 6:25 A.M., the flour and sugar bulk bins with lids caked with a white powder substance; -At 6:33 A.M., the walk-in freezer with trash and food debris on the floor in multiple areas. 4. Observation on 7/10/24 at 6:25 A.M., of the breakfast preparation, showed [NAME] MM came up to the prep station to assist [NAME] Q with breakfast preparation. [NAME] MM grabbed the uncovered cooked eggs and started to place them into tins for the steam table. [NAME] MM did not wear a beard net and had a beard approximately 3/4 of an inch long. Observation on 7/11/24 of the lunch preparation showed: -At 9:01 A.M., [NAME] MM grabbed a tin of cooked chicken and started to puree the chicken and placed the chicken into a tin for the steam table. [NAME] MM did not wear a beard net and had a beard approximately 3/4 of an inch long; -At 9:16 A.M., [NAME] MM grabbed a tin of mixed veggies and started to puree the veggies and placed them into a tin for the steam table. [NAME] MM did not wear a beard net and had a beard approximately 3/4 of an inch long. 5. During an interview on 7/15/24 at 9:44 A.M., [NAME] Q said all dietary staff are responsible for cleaning the floors and prep stations in the kitchen across all shifts. The Dietary Manager and cook are responsible for cleaning appliances. [NAME] nets are to be worn anytime a staff member with a beard is around food to avoid hair from contaminating the food. During an interview on 7/15/24 at 9:47 A.M., the Dietary Manager said all dietary staff are responsible for cleaning the floors in the kitchen and walk in freezer, bulk bin lids, and appliances. The Dietary Manager is responsible for cleaning fans. He would expect for the kitchen and appliances to be clean. [NAME] nets are required to be worn anytime food preparation is in process. He would expect his staff to be wearing a beard net. During an interview on 7/15/24 at 2:56 P.M., the Administrator said she would expect the kitchen and all appliances to be clean to policy standards. She would expect staff to be wearing a beard net when food preparation is in process.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 40290 Based on interview and record review, the facility failed to have a complete and thorough facility-wide assessment to determine what resources are necessary to care for the residents competently during both day-to-day operations and emergencies. The facility assessment did not include staffing ratios required per shift to meet the needs of residents, the need for a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, or the facility's use of locked units for residents identified with cognitive impairments and behaviors. The census was 151. Review of the facility's Facility Assessment, updated 12/13/23, showed: -Persons involved in completing assessment: Administrator, Director of Nursing (DON), Medical Director, Governing Body Representative (representative from facility's corporation); -Resident acuity, per major resource utilization guidelines (RUGs), number/average or range of residents: -Rehabilitation plus extensive services: 72; -Rehabilitation: 71; -Extensive services: 1; -Special care, high: 21; -Special care, low: 6; -Clinically complex: 4; -Behavioral symptoms and cognitive performance: 8; -Reduced physical function: 26; -Staffing plan: General staffing plan to ensure sufficient staff to meet the needs of the residents at any given time: -Licensed Nurses: 1 DON, 2 Assistant Directors of Nursing (ADON), 2 RN or Licensed Practical Nurse (LPN) charge nurse; -Direct care staff: Ratio for days, evenings and nights, blank; -Other (e.g., department heads, nurse educator, quality assurance, ancillary staff in maintenance, housekeeping, dietary, laundry: 2 wound nurses; (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-No documentation of ratios of direct care staff, restorative therapy staff, Social Services staff, dietary staff, housekeeping and laundry staff necessary on each shift to ensure the needs of residents are met; -No documentation of the need for a RN at least eight consecutive hours a day, seven days a week; -No documentation for the use of one locked unit utilized for residents identified with cognitive impairments and/or wandering behaviors, and two locked units utilized for residents identified with behaviors. During the course of the survey process, problems were identified which included: -Insufficient nursing staff available to meet the needs of residents, as evidenced by staff interviews, residents with missed treatments, and residents with missed activities of daily living (ADL) care; -A RN was not scheduled eight consecutive hours a day, seven days a week; -Lack of a restorative program. During an interview on 7/16/24 at 11:17 A.M., the Administrator said the facility assessment is developed by the Administrator and reviewed by the facility's Regional office and facility's interdisciplinary team. The facility assessment is updated annually unless needed otherwise. She expects the facility assessment to accurately reflect the facility's general staffing needs, including staff ratios. Facility assessment should include all of the facility's resources as they pertain to the building structure, including the use of locked units on the second and third floors of the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40290 Based on observation, interview, and record review, the facility failed to maintain medical records that are complete and accurately documented in accordance with acceptable professional standards and practices and with the facility's policies, when staff revised an assessment completed three months ago for one resident (Resident #45). The sample was 30. The census was 151. Review of the facility's Falsification and Omission policy, revised 10/24/22, showed: -Purpose: To ensure entries in the medical records provide an accurate description of the services provided; -Policy: Entries in a medical record at the facility will be factual and will accurately reflect the services provided to the resident, the condition of the resident, and the resident's response to services provided; -Procedure: -The original entry in a record is not to be destroyed or removed from the record; -Errors in the record may be corrected or amended. See policy Completion and Correction; -A deficiency in any omitted entry or incorrect entry that is not knowingly omitted or documented incorrectly; -Willful material falsifications and omissions are prohibited. Review of the facility's Completion and Correction policy, revised 10/24/22, showed: -Purpose: To ensure that medical records are complete and accurate; -Policy: The facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation; -Procedure: -Entries will be recorded promptly as the events or observations occur; -Entries will be complete, legible, descriptive and accurate; -Entries will be permanent, either electronically or legibly written in permanent ink and capable of being photocopied or printed; -No portion of the record is to be obliterated, erased, or destroyed; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If an error needs to be corrected, draw one line through the entry, designate the entry as an error, and initial next to the change; -An addendum provides additional information to address a specific situation or incident; -Clarification is a type of late entry used to clarify a previous entry to avoid incorrect interpretation of information that has been previously documented; -Designate the information as clarification and state the reason for the clarification referring back to the original entry; -Electronic Records: -Correcting an error in an electronic/computerized medical record system follows the same principles as correcting a paper record; -When correcting or making a change to a signed entry, the original entry must be viewable, the current date and time entered, and the person making the changed identified. Review of Resident #45's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/26/24, showed the following: -Cognitively intact; -Diagnoses included malnutrition, anxiety, depression, psychotic disorder, bipolar disease (mood disorder that can cause intense mood swings); -Use of feeding tube. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Resident has declined to allow staff to administer his/her medication via oral route as directed; -Goal: Resident will have his/her medications administered as directed; -Interventions: Encouragement and retraining needed to allow resident to regain taste sensation of medication, monitor his/her intake of medications, if nausea/vomiting persists administer his/her medications via feeding tube and document; -The care plan did not identify the resident as being able to self-administer his/her medications. Review of the resident's quarterly Medication Self-Administration Screen, dated 4/23/24, reviewed 7/10/24 at 8:08 A.M., showed: -No medications listed; -Interdisciplinary team (IDT) feels resident is safe to self-administer listed medications: No; (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident agrees to terms and policies for self-administration: No; -Date of agreement: Blank; -Physician order: Resident may not self-administer medications; -Category: Resident may not self-administer medications. Review of the resident's electronic physician order sheet (ePOS), reviewed 7/10/24 at 8:35 A.M., showed no orders for the resident to self-administer his/her medications. Review of the resident's progress note, dated 7/8/24 at 11:43 A.M., showed the resident requested to self-administer medication through the feeding tube . Staff made medical director (MD) aware. MD declined to give order and stated that nurse must give resident his/her medication. The resident and Director of Nursing (DON) made aware. Observation on 7/11/24 at 7:30 A.M., showed Licensed Practical Nurse (LPN) J prepared medications for the resident at the nurse's station. He/She crushed the resident's medication and placed the medication into a 5 milliliter (ml) medication cup and walked to the resident's room. LPN J filled a graduate (container used to measure liquids) with warm water from the sink in the resident's room, added an unmeasured amount to the medication cup, and handed the resident the cup of fluid containing medications. The resident exposed his/her abdomen and produced the gastrostomy tube (g-tube, a tube surgically inserted into the stomach to provide hydration, nutrition, and medications), removed the stopper and inserted an empty syringe in the g-tube. The resident poured approximately half of the liquid containing medication into the syringe, a large amount of air remained in the syringe. He/She placed the plunger at the end of the syringe and then pushed the liquid containing medications in quickly and with force approximately 9 cubic centimeters (cc) of air also injected into the stomach. The resident removed the syringe from the g-tube slightly to allow the plunger to be removed without resistance. The resident placed the syringe back into the g-tube, poured more of the fluid containing medication into the syringe, a large amount of air remained in the syringe, inserted the plunger, and pushed the medications in quickly and with force. The resident removed the syringe from the g-tube slightly to allow the plunger to be removed without resistance. The resident then poured water from the graduate into the cup containing residual medications. The resident placed the syringe back into the g-tube, poured the remaining fluid in the medication cup and a large amount of air remained in the syringe. He/She inserted the plunger, and pushed the medications in quickly and with force. The resident replaced the stopper and laid back onto his/her bed. LPN J observed the resident administering medication, did not cue the resident to allow the medication to be administered via gravity, did not cue the resident not to push air into the stomach, and did not provide education on the risks of inserting air into the stomach. During an interview on 7/11/24 at 8:47 A.M., LPN J said the resident will not allow staff to flush, administer the medication, or apply the gauze to the g-tube site. The resident has a history of refusing the medications if staff attempt to provide medications and treatments as ordered. The resident needs constant reminders to not push so much air into the stomach while administering the medications. Review of the resident's quarterly Medication Self-Administration Screen, dated 4/23/24, reviewed 7/11/24 at 10:54 A.M., showed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Document revised by MDS Coordinator on 7/11/24; -Seven medications listed; -IDT review summary: Narcotic dependence; -IDT feels resident is safe to self-administer listed medications; Yes; -Resident agrees to terms and policies for self-administration: Yes; -Date of agreement: 1/26/24; -Physician order: Resident may self-administer medications with supervision; -Category: Resident may self-administer medication with supervision; -All fields on the previous assessment, dated 4/23/24, and reviewed 7/10/24 at 8:08 A.M. were revised and the original content no longer visible. During an interview on 7/16/24 at 10:20 A.M., the MDS Coordinator said this morning, she reviewed the resident's self-administration assessment completed in April 2024. She determined the assessment was incorrect. The resident can safely administer his/her own medications and the MDS Coordinator educated the resident on how to do so. The resident's quarterly self-administration of medication assessment is due. The MDS Coordinator did not revise the assessment completed three months ago on purpose. She meant to generate a new quarterly assessment for self-administration of medication. Staff should document accurately in resident records. During an interview with the DON and Administrator on 7/16/24 at 11:17 A.M., the DON said the charge nurse is responsible for completing assessments for self-administration. The assessment determines whether a resident is safe or unsafe to self-administer their medications. If the resident is safe to administer their medications, a physician order should be obtained and staff should supervise and cue the resident during the administration. The Administrator said if the resident's condition has changed since their previous assessment, she expects staff to complete a new assessment at that time. It is not appropriate to revise an assessment from months ago.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42795 Based on observation, interview, and record review, the facility failed to follow acceptable standards of practice for infection prevention and control, when staff failed to utilize Enhanced Barrier Precautions (EBP), an infection control method that uses personal protective equipment (PPE), gowns and gloves, to reduce the spread of multidrug-resistant organisms (MDRO, a germ resistant to many antibiotics), for one resident (Resident #22). In addition, the facility failed to use proper infection control techniques when obtaining blood glucose and administering insulin to one resident (Resident #133). The sample was 30. The census was 151. Review of the facility's Standard and Enhanced Precautions policy, revised 4/1/24, showed: -Purpose: To ensure the use of appropriate protective equipment to improve infection control as required in the care of the residents; -Policy: The facility will utilize current guidance from the Centers for Disease Control (CDC) and the Centers for Medicare and Medicaid Services (CMS) to determine the appropriate PPE to be utilized during the care of residents to minimize the risk for infection or spread of infection; -EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employees targeted gown and glove use during high contact resident care activities that are associated with a high risk MDRO colonization when contact precautions do not otherwise apply and or transmission such as presence of indwelling devices (urinary catheter, a tube that drains urine from the bladder), feeding tube, tracheostomy tube (a surgically created hole in the windpipe that assists with breathing), vascular catheters (a flexible tube inserted into the blood vessel to access the blood stream), wounds or presence of unhealed pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure to the skin); -For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: Dressing, bathing, showering, transferring, providing hygiene care, changing linen, changing briefs or assisting with toileting, vascular catheters, urinary catheter, feeding tube, tracheostomy, and wound care that has a skin opening and requires a dressing; -EBP are intended to be in place for the duration of a resident's stay in the facility or until the resolution of the wound or discontinuation of the indwelling medical device that placed them at high risk. 1. Review of Resident #22's, quarterly Minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 5/17/24, showed: -The resident is rarely understood; -Has impairment to upper and lower extremities; -Requires substantial to maximal assist for personal and toileting hygiene; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Always incontinent of bowel and bladder; -Nutritional approaches: feeding tube. Review of a list of residents on EBP provided by the facility showed the resident was not listed. Observation on 7/9/24 at 11:28 A.M., showed a sign posted on the resident's door related to EBP: STOP, providers and staff must wear gloves and gown for high contact resident care activities. No PPE was located outside the resident's door. The resident had vomited a large amount of emesis that covered his/her sheets and gown. Restorative Aide W and Certified Nursing Assistant (CNA) V entered the resident's room without a protective gown on. Restorative Aide W and CNA V cleaned the resident's face with a washcloth, removed his/her top sheet, and gown. The resident had a feeding tube in place in his/her abdomen. The resident's brief was soiled, Restorative Aide W and CNA V provided peri-care (cleansing of the genitals and buttock area) to the resident and changed the resident's bed pad by turning the resident side to side. The resident's bare knees touched Restorative Aide W's and CNA V's scrub tops while they were turning the resident. The resident was repositioned, a new gown was applied, and the resident was provided a clean top sheet. Restorative Aide W and CNA V did not have a protective gown on during the entire duration of care to the resident. During an interview on 7/15/24 at 9:24 A.M., CNA QQ said staff are supposed to wear a gown, masks, and gloves when the EBP signs are posted on the resident's door. During an interview on 7/15/24 at 9:32 A.M. Licensed Practical Nurse (LPN) SS and the facility Wound Nurse said they knew absolutely nothing about EBP. They had seen the signs on the door, but were unsure what criteria and what interventions were involved. During an interview on 7/15/24 at 9:38 A.M., CNA RR said he/she was aware of the signs of the door, but was not entirely sure what the criteria was for EBP or what it meant. During an interview on 7/16/24 at 7:56 A.M., the MDS Nurse said she was also the Infection Preventionist (IP). Staff are expected to follow the EBP sign posted on the resident's door. When the sign is posted, staff are to wear the appropriate PPE. The resident has a feeding tube, so staff should have worn a protective gown in addition to gloves while providing care. The purpose of EBP is to prevent the spread of infections to the vulnerable population. During an interview on 7/16/24 at 11:16 A.M., the Director Of Nursing (DON) said the resident is on EBP because the resident has a feeding tube. It is expected that staff follow the EBP signs when indicated to decrease the spread of infection. A gown should have been worn when staff provided care to the resident. 2. Review of the competency checklist for the Blood Glucose Monitoring (BGM), Subcutaneously, under layers of the skin (SQ) Injections, and Blood Glucose Meter Cleaning, undated, showed: -Perform hand hygiene; -Complete the cleaning and disinfecting the blood glucose meter before and after each blood glucose testing event; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Remove the disinfectant wipe from the container. Use the wipe to clean the surface of the workspace and dispose of the wipe. Place a dry paper on the workspace to use as a barrier; -Remove gloves and perform hand hygiene; -Position the resident to expose the finger to be pricked. Determine the resident's preference; -Clean the area of the finger that will be punctured with an alcohol pad. Allow the finger to air dry; -Obtain the sample; -Remove gloves and perform hand hygiene; -Document the results in medical record; -Clean injection site with an alcohol wipe, beginning at center of the site moving outward in a circular motion; -Remove gloves and wash hands; -Clean the glucose meter and store in a clean, dry drawer or container. The facility was not able to provide a policy on Insulin Administration. Review of Resident #133's face sheet, undated, showed diagnoses including diabetes. Review of the resident's Physicians Order Sheet (POS), dated July, 2024, showed: -Lispro (fast acting insulin) 100 unit/milliliters (ml), SQ per sliding scale (a scale used to determine the amount of insulin to be administered based off of the result of the blood glucose level); -There was no order for BGM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/11/24 at 12:18 P.M., showed Certified Medication Technician (CMT) AA near the nurse's station, pushing the medication cart to the resident room. He/She put on gloves and did not complete hand hygiene, opened a drawer in the medication cart, grabbed the basket containing the glucometer and supplies. CMT AA removed the glucometer, did not clean the glucometer and placed the device on the top of the medication cart, with no barrier in place. With a gloved hand, CMT AA opened the bottle of strips, removed a strip, placing it on the top of the medication cart, where there was no barrier. He/She grabbed the monitor, a strip, a lancet and an alcohol wipe, reviewed the computer screen, placed the strip in the glucometer, and walked into the resident's room. The resident showed CMT AA the finger he/she wanted used to check his/her blood sugar. CMT AA, with the same gloves massaged the finger and then used the lancet to stick the finger. After several unsuccessful attempts to produce blood, he/she wiped the resident's finger with an alcohol wipe and placed the glucometer on the resident's bedside table without a barrier. Returning to the medication cart, he/she discarded the strip in the sharps container (a contained box where sharp objects are placed to prevent harm), changed gloves, but did not perform hand hygiene, collected a lancet, strip and alcohol wipe. CMT AA returned to the resident, placed the strip into the glucometer, selected a different finger, and used the lancet to stick a finger. Blood formed on the resident's finger. CMT AA collected a sample of blood with the glucometer and strip. CMT AA then cleaned the resident's finger with the alcohol pad and returned to the medication cart, placed the glucometer with the used strip on the top of the medication cart. He/She reviewed the computer screen, he/she pulled the soiled strip out of the glucometer, and placed the glucometer in the basket that contained lancets, alcohol pads and a bottle containing strips and discarded the strip into the sharps container. CMT AA did not clean the glucometer. CMT AA removed his/her gloves, did not perform hand hygiene and applied another pair of gloves. The resident's blood glucose result was 398, he/she wiped the top of the bottle of Lispro insulin, filled the syringe with ten units of Lispro insulin and entered the resident's room, informed the resident he/she was going to inject the insulin to the right lower quadrant of the stomach. The resident raised his/her shirt, CMT AA placed his/her hand on the abdomen and then injected the insulin without cleaning the injection site. He/She wiped the injection site with an alcohol wipe and returned to the medication cart and discarded the needle in the sharps container. During an interview on 7/16/24 at 7:56 A.M., the MDS Nurse said she was also the IP. Anytime a CMT puts on and takes off gloves they should wash their hands. CMTs should not put gloves on at the nurse's station and then proceed to administer medications or treatments to residents. CMTs should use a barrier as a clean surface to place the clean equipment. CMTs should clean the site before and after a finger stick and injections. Glucometers should be cleaned prior to and after use. The importance of the handwashing, hand hygiene and a barrier are to prevent the spread of infection. Staff who perform finger sticks and injections complete competencies. The most recent competency event was within the last three months, but she could not provide the exact date. During an interview on 7/16/24 at 12:30 P.M., the DON said she expected staff to use proper hand hygiene, and to use the alcohol wipes to clean the site for a finger stick and injection. She expected the glucometer to be cleaned before and after use, and a barrier to be used while performing the finger sticks. The importance of the handwashing, hand hygiene and a barrier are to prevent infection. 49992

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 42795 Based on interview and record review, the facility failed to establish an Antibiotic Stewardship Program (ASP) that included antibiotic use protocols and a system to monitor antibiotic use. The census was 151. Review of the facility's ASP, revised 10/24/22, showed: -Purpose: To limit antibiotic resistance in the post-acute care setting, improve treatment efficacy and resident safety, and reduce treatment-related costs; -Policy: ASP is designed to promote appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use; -Procedure: -The Infection Preventionist (IP), a medical professional that develops ways to detect, prevent and control the spread of infections in residents at the facility, and Medical Director will set standards for the use of antibiotics after reviewing antibiotic trends from the previous quarter and outcome reports; -These standards will be updated as indicated, but no less than annually; -The IP, or other similarly qualified healthcare professionals, will educate nursing staff to obtain and communicate pertinent clinical information to physicians to promote appropriate diagnosis and prescribing of antibiotics; -The Infection Control Committee (ICC) will review infections and monitor antibiotic usage patterns on a regular basis. In addition, the ICC will obtain and review results from microbial cultures, resistant organisms, alerts and antibiotics from the lab for trends of resistance; -The Consultant Pharmacist will review the antibiotic prescribing practices of active antibiotic orders during his/her monthly drug regimen review; -The Consultant Pharmacist will prepare a written report documenting potential areas for improvement, irregularities, and recommendations. This report will be shared with the ICC and/or the Quality Assessment and Assurance Committee (QAC). -The IP will report on number of antibiotics prescribed (days of therapy) and the number of residents treated each month to the Consultant Pharmacist. -The IP will collect and analyze infection surveillance data and monitor the adherence to the ASP and create a report for the Consultant Pharmacist identifying the number of residents on antibiotics that did not meet criteria for active infection and suggest appropriate overall changes to make it a successful, well-rounded program; (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Tracking: -The IP will be responsible for review of infection surveillance and multi-drug resistant organisms (MDRO), a germ resistant to many antibiotics, tracking; -The IP will utilize antibiotic tracking sheet; -The Consultant Pharmacist will review and report antibiotic usage data collected by IP each month during their drug regimen review process to include the above medication safety criteria; -The IP will measure and report outcomes and success rate at monthly/quarterly ICC meetings. Review of a list of residents on antibiotics provided by facility showed ten residents had active orders for antibiotics. During an interview on 7/9/24 at 2:27 P.M., the facility's Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility, Nurse said she recently took over the ASP and the IP role after the last Director Of Nursing (DON) left. She did not have a current tracking system or surveillance for antibiotics and did not know where the previous tracking and surveillance information the previous DON had was located. During an interview on 7/11/24 at 8:10 AM., the Wound Nurse said she would like to see some type of antibiotic log or tracking so she could determine a more refined plan of care for residents who have infected wounds. She was not aware if the facility had a current ASP in place. During an interview on 7/17/24 at 11:16 A.M., the Administrator and the DON said antibiotic stewardship is expected to be utilized by the facility to track and monitor the residents who have orders for antibiotics. The IP is responsible to establish and maintain the ASP.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40290 Based on observation, interview, and record review, the facility failed to ensure beds in three shared rooms were equipped with curtains to assure full visual privacy for each resident (Residents #37, #126, and an unidentified resident). The census was 151. 1. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/10/24, showed: -Severe cognitive impairment; -Diagnoses included Alzheimer's disease. Observation on 7/8/24 at 10:08 A.M., showed no privacy curtain hung around the resident's bed. Observation on 7/9/24 at 8:33 A.M., showed no privacy curtain hung around the resident's bed. The resident stood next to his/her bed while Certified Nurse Aide (CNA) E assisted him/her in getting undressed. The resident's roommate sat in a chair on his/her side of the room, in full line of sight of the resident getting undressed. Observations of the resident's room on 7/11/24 at 8:50 A.M., 7/12/24 at 11:55 A.M., and 7/15/24 at 7:31 A.M. , showed no privacy curtain hung by the resident's bed. 2. Review of Resident #126's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -Diagnoses included dementia. Observation on 7/8/24 at 10:02 A.M., showed no privacy curtain hung around the first bed in the room. During an interview, the resident said he/she shared a room with another resident. He/She had a curtain around his/her bed, but the roommate did not. Observations of the resident's room on 7/9/24 at 9:20 A.M., 7/11/24 at 8:48 A.M., 7/12/24 at 9:41 A.M., and 7/15/24 at 7:31 A.M., showed no privacy curtain hung by the resident's roommate's bed. 3. Observations of room [ROOM NUMBER], shared by two unidentified residents, on 7/12/24 at 9:41 A.M. and 7/15/24 at 7:31 A.M., showed no privacy curtain hung by either bed. 4. During an interview on 7/15/24 at 2:48 P.M., CNA R said there should be a curtain hung by each resident's bed to ensure privacy. A couple of resident rooms were missing privacy curtains. Missing privacy curtains should be reported to housekeeping or maintenance. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/24 at 7:39 A.M., Housekeeper KK said each resident's bed should have its own privacy curtain. Housekeeping staff clean resident rooms daily. If they noticed a privacy curtain is missing or soiled, they report it to their supervisor. If the privacy curtain is soiled, maintenance staff will remove the privacy curtain and take it to laundry. He/She is not sure who puts the privacy curtains back up. During an interview on 7/16/24 at 8:32 A.M., the Housekeeping/Laundry Director said each resident bed should have its own privacy curtain. Housekeeping staff clean resident rooms daily and if they notice a privacy curtain is soiled, they report it to maintenance, who removes the curtain and has it sent to laundry. The privacy curtain should be returned to the resident's room within the same day. The facility is short on privacy curtains, which are currently on order. During an interview on 7/16/24 at 10:32 A.M., the Maintenance Director said he was not aware of any missing privacy curtains in rooms on the second floor. He expected staff to report missing privacy curtains to him. Each resident's bed should have its own privacy curtain. During an interview on 7/16/24 at 11:17 A.M., the Administrator said each resident bed should be equipped with a privacy curtain. Nursing and housekeeping staff should report any missing privacy curtains to the Housekeeping/Laundry Director, Central Supply, or the Administrator. An audit was completed last week to identify which privacy curtains were missing and what sizes are needed. The needs have been identified and now it is a matter of ordering the privacy curtains. MO00238490

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

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42795 Based on interview and record review, the facility failed to establish and maintain a tracking system for Certified Nursing Assistant (CNA) 12 hour training requirements for five out of five sampled CNAs. The census was 151. A policy related to CNA 12-hour training was not provided by the facility. Review of the five sampled CNAs' (CMT HHH, CMT OO, CNA E, CNA T, and CNA M) employee training records showed: -Multiple dated in-services and education sheets signed by the CNAs. The signed in-service and education sheets did not list the amount of time each in-service had taken. -No further documentation of tracking the in-services for each CNA provided by the facility. During an interview on 7/10/24 at 4:10 P.M., CNA T said the facility was always in- servicing and providing education, but didn't think the facility was officially tracking the mandatory 12 hours. During an interview on 7/16/24 at 11:16 A.M., the Administrator said the facility was always providing education and in-services to the CNAs, but she had failed to organize and track the yearly mandatory 12 hour trainings for the facility CNAs to ensure they are being completed.