STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175500	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hill Top House	505 W Elm Bucklin, KS 67834

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 21 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a baseline care plan within 48 hours of admission for Resident (R) 123. This placed the resident at risk for impaired care due to unidentified or uncommunicated care needs. Findings included: - R123's Electronic Medical Record (EMR) recorded diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), urinary incontinence, hypertension (high blood pressure), gastroesophageal reflux disease (GERD-backflow of stomach contents to the esophagus), nutritional deficiencies, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), irritable bowel syndrome (IBS- abnormally increased motility of the small and large intestines), a history of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain) and cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) without residual deficits. The Entry Tracking Record Minimal Data Set (MDS) dated [DATE] recorded R123 admitted on [DATE] from home or the community. R123's clinical record lacked a baseline care plan from the admitted [DATE]. The Physician Order dated 11/08/24, directed staff to admit to the nursing home long-term care with diagnoses of diabetes, urinary incontinence, and a history of stroke. The Progress Note, dated 11/08/24 at 01:38 PM, documented R123's arrival at the facility via personal vehicle. Vital signs were obtained, and a family member assisted the resident with unpacking and getting the room situated as R123 wanted. On 11/19/24 at 12:23 PM, observation revealed staff escorted R123 to her room. R123 reported she did not feel well and was dizzy. Licensed Nurse (LN) G obtained vital signs and a blood sugar level. R123's blood sugar level was low. LN G reported that R123 had a history of low blood sugar levels since admission. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/20 at 01:00 PM, LN G reviewed R123's EMR and verified there was no baseline care plan. On 11/20/24 at 11:30 AM, Administrative Nurse D verified R123's EMR lacked a baseline care plan and said one should have been developed within 48 hours of admission. The facility's undated Interim Temporary Care Plans policy documented an interim plan of care is developed and initiated on admission to the facility. Continual evaluation of interim, temporary plans of care was completed by staff members caring for the elder. Revisions to the care plan will be ongoing and the current conditions, needs, and goals of the elder change. The facility failed to develop a baseline care plan within 48 hours of admission. This placed R123 at risk for impaired care due to unidentified and uncommunicated care needs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37450 The facility had a census of 21 residents. The sample included 12 residents and five nurse aides. Based on observation, record review, and interview, the facility failed to ensure three of the five staff members reviewed possessed the knowledge, skills, and competencies required for resident care needs. This placed the residents at risk of impaired care. Findings included: - Review of the training records and skills check for Certified Nurse Aide (CNA) O, P, and Q lacked evidence of the facility's procedure checklist related to the direct care of the residents. On 11/20/24 at 10:33 AM, Administrative Nurse D stated the facility had conducted a skills check-off the previous summer for the nursing staff, and not all employees attended. Administrative Nurse D stated the facility had not rescheduled or completed any further competencies for staff who did not attend. The facility's undated Required Training of Nurse Aides documented the facility would ensure that nurse aides demonstrate competency in skills and techniques necessary to care for residents as identified through resident assessments and described in the plan of care. The facility failed to ensure three of the five staff members reviewed possessed the knowledge, skills, and competencies required for resident care needs. This placed the residents at risk of impaired care.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 21 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to obtain a stop date from the physician for the use of as-needed (PRN) lorazepam (antianxiety medication) for Resident (R) 9. This placed the resident at risk for complications related to psychotropic (alters mood or thought) medications and unnecessary medication. Findings included: - R9's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). The Significant Change Minimum Data Set (MDS), dated [DATE], documented that R9 had short- and long-term memory problems with severely impaired cognition. The MDS documented R9 received hospice (end-of-life) services and did not receive antianxiety drugs. R9's Care Plan, dated 11/14/24, documented R9 had Alzheimer's dementia and anxiety. R9 could become agitated with care at times, including hitting and slapping. The care plan directed staff to provide opportunities for positive interaction and attention and directed staff to stop and talk with her when passing by, initiated 06/13/23. The plan directed staff to monitor behavior episodes, attempt to determine underlying causes, and document behavior and potential causes, initiated on 06/13/23 and revised on 10/25/23. The plan directed to administer psychotropic medications as ordered and monitor for side effects and effectiveness every shift initiated 06/13/23. The plan directed staff to discuss with the physician and family the ongoing need for the use of medication and review behaviors and interventions and alternate therapies attempted and their effectiveness as per facility policy, initiated on 06/13/23. Staff were to monitor, document, and report any adverse reactions to psychotropic medications, initiated on 06/13/23 and revised on 10/25/23. The Physician Order, dated 11/04/24, directed staff to administer lorazepam oral concentrate 0.25 milliliter (ml) every four hours as needed for agitation or restlessness. The order stated duration was indefinite. On 11/19/24 at 08:13 AM, observation revealed Certified Nurse Aide (CNA) M woke R9 and told R9 what she was doing. While CNA M provided incontinence care, R9 frowned but did not cry out. R9 made a small noise during the transfer from her bed to a wheelchair. CNA M stated that R9 used to become more upset when staff worked with her, but she had declined. On 11/19/24 at 01:58 PM, Licensed Nurse (LN) G stated R9 was more alert before her health declined and would become agitated with care, striking out at staff. LN G said staff monitored how many times each shift R9 had restlessness, agitation, and hitting. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 09:35 AM, Administrative Nurse D verified when a physician ordered PRN lorazepam, staff should obtain a specific stop date. The facility's Psychotropic Medication Use policy stated any resident admitted with a PRN psychoactive medication would have a 14-day stop date. Any psychotropic medication ordered by a physician as an emergency treatment for behaviors would have an automatic 72-hour stop date during which the physician and nursing staff would assess the potential root cause for the behaviors and interventions that may replace or be used as adjunct therapy for the behaviors. The physician's order must include a qualifying diagnosis and a list of specific targeted behaviors for which the staff would monitor. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior. The facility failed to obtain a stop date from the physician for the use of PRN lorazepam for R9, placing the resident at risk for complications related to psychotropic medications and unnecessary medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 21 residents. The sample included 12 residents with two reviewed for hospice services. Based on observation, interview, and record review the facility failed to ensure a communication process and collaboration between the hospice provider and the facility for Resident (R) 9 and R17 to coordinate hospice services provided including visit frequency and assessment, medications, and medical equipment. This placed the residents at risk of impaired end-of-life care. Findings included: - R9's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), and dementia (a progressive mental disorder characterized by failing memory and confusion) with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). The Significant Change Minimum Data Set (MDS), dated [DATE], documented that R9 had short- and long-term memory problems with severely impaired cognition. The MDS documented R9 received hospice services. R9's Care Plan, dated 11/14/24, documented R9 had Alzheimer's dementia and anxiety. R9 could become agitated with care at times, including hitting and slapping. The care plan directed staff to provide opportunities for positive interaction and attention and directed staff to stop and talk with her when passing by, initiated 06/13/23. The plan directed staff to monitor behavior episodes attempt to determine underlying causes, and document behavior and potential causes, initiated on 06/13/23 and revised on 10/25/23. The plan directed to administer psychotropic medications as ordered and monitor for side effects and effectiveness every shift initiated 06/13/23. The plan directed staff to discuss with the physician and family the ongoing need for the use of medication and review behaviors and interventions and alternate therapies attempted and their effectiveness as per facility policy, initiated on 06/13/23. Staff were to monitor, document, and report any adverse reactions to psychotropic medications, initiated on 06/13/23 and revised on 10/25/23. The care plan directed staff to allow R9 time to answer questions and to verbalize feelings, perceptions, and fears daily. The care plan directed staff to consult with pastoral care or social services, initiated on 12/06/23. The care plan lacked any mention of hospice services. A review of R9's clinical record lacked information regarding hospice staff assessments, care, or visits. On 11/19/24 at 08:13 AM, observation revealed Certified Nurse Aide (CNA) M woke R9 and told R9 what she was doing. While CNA M provided incontinence care, R9 frowned but did not cry out. R9 made a small noise during the transfer from her bed to a wheelchair. CNA M stated that R9 used to become more upset when staff worked with her, but she had declined. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:37 AM, Certified Nurse Aide (CNA) N and CNA O stated the charge nurse usually let CNA staff know if a resident was on hospice. They reported there was a list in the shower room that documented who hospice was giving a shower or bath and when. They also stated that the residents on hospice got incontinence products from the hospice company. They stated that the hospice also provided equipment, like wheelchairs and oxygen. On 11/19/24 at 01:25 PM, CNA M verified that R9 received hospice services. CNA M said the hospice nurse visited weekly and the hospice aide came weekly to bathe R9. On 11/19/24 at 02:20 PM, Licensed Nurse (LN) G stated the last hospice care plan was dated 11/06/24 and verified the facility's care plan did not include any hospice information. She verified the facility did not receive hospice assessment findings or visit notes. The facility's Hospice Agreement, dated 05/15/18, was last signed on 05/01/20 by both parties. The nursing facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each residential hospice patient receiving facility and hospice services. Each clinical record shall completely and accurately document all services provided to and events concerning (including evaluations, treatments, progress notes, and physician orders for each hospice patient. The nursing facility and hospice shall each retain the records and the records shall be readily accessible and organized. to facilitate retrieval by either party. The facility failed to ensure a communication process and collaboration between the hospice provider and the facility for R9. This placed the resident at risk of impaired end-of-life care. 37450 - R17's Electronic Medical Record (EMR) included diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), non-displaced fractures (broken bone) of the second cervical (neck/spine) vertebra, second and third thoracic (mid back area) vertebra (bone of the spinal column), first, third, and fourth lumbar (lower spine) vertebra, osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) with a current pathological fracture (a break in a bone that is caused by an underlying disease), and nutritional deficiency. The Significant Change Minimum Data Set (MDS), dated [DATE], documented R17 had moderately impaired cognition. R17 required partial/moderate assistance with personal hygiene and upper body dressing, and substantial/extensive assistance with toileting, lower body dressing, bathing, bed mobility, and transfers; walking was not attempted due to medical condition or safety concerns. R17 was occasionally incontinent of urine. R17 received scheduled and as-needed pain medication for pain which was frequent and affected sleep and day-to-day activities. The MDS further documented that R17 received hospice services (specialized end-of-life care with a focus on comfort). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R17's Care Plan dated 09/26/24, documented R17 received hospice care services. The care plan directed staff to adjust provisions of activities of daily living to compensate for the resident's changing abilities, assess and respect the resident's wishes, encourage support systems of family and friends, and keep the environment quiet and calm. The care plan further directed staff to observe R17 closely for signs of pain, administer pain medication, and work cooperatively with the hospice team to ensure the resident's, spiritual, emotional, intellectual, physical, and social needs were met. The care plan lacked specific information related to the hospice provider, services and equipment or medications that would be provided, and when to notify the hospice provider. The Hospice Order dated 09/18/24, documented R17's hospice provider, and diagnoses of CHF and fractures. R17 had her neck brace, and the hospice provider would provide pull-ups, a skilled nurse weekly, and a nurse aide two times a week. The orders included medications covered under R17's hospice benefit. The Progress Note dated 09/11/24 at 01:13 PM, documented R17's primary care practitioner asked staff to Please discuss comfort care and or hospice with R17's family and the charge nurse was to address R17's power of attorney about changes. The Progress Note dated 09/12/24 at 02:15 PM, documented the facility nurse spoke with R17's family and spouse about hospice care. The hospice social worker was in to meet with the family. The Progress Note dated 09/12/24 at 05:29 PM, documented the hospice nurse called to relay that as of 09/12/24, R17 was admitted to hospice. Upon review, R17's clinical record lacked evidence of the hospice assessment findings and hospice nurse visit notes. On 11/18/24 at 02:20 PM, observation revealed R17 sat in a recliner in her room with a family member next to her. R17 reported she was doing okay. R17 had the footrest elevated and a small, rolled blanket to the back of her neck. On 11/19/24 at 11:37 AM, Certified Nurse Aide (CNA) N reported staff received information from the charge nurse when a resident was receiving hospice services. CNA N stated the hospice provider would usually provide incontinent products, a wheelchair, and oxygen. CNA N stated the shower list had when a hospice aide would bathe the resident. On 11/19/24 at 03:31 PM, Licensed Nurse (LN) G reported the facility did not have a hospice book or chart for R17. LN G reported the facility staff signed the hospice staff's tablets confirming the hospice staff visit and that the hospice nurse and facility nurse verbally discussed the resident's condition. LN G was unable to find the hospice nurse documentation of assessments or ongoing collaboration in R17's EMR. LN G reported the hospice plan of care was sent to the facility via email every six months with the recertification of hospice services. On 11/20/24 at 10:33 AM, Administrative Nurse D verified the hospice provider should send notes from all visits made which should be scanned into the EMR. Administrative Nurse D reported the hospice provider had a change in computerized record keeping and was unaware the hospice provider had not been sending the information from the visits until recently. Administrative Nurse D said the facility had not followed up on receiving information from the hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Hospice Agreement dated 05/15/2018, last signed 5/1/20 by both parties documented that the nursing facility and hospice shall each prepare and maintain complete and detailed clinical records concerning each residential hospice patient receiving facility and Hospice services. Each clinical record shall completely and accurately document all services provided to and events concerning (including evaluations, treatments, progress notes, and physician orders of each) hospice patient. The nursing facility and hospice provider shall each retain the records and the records shall be readily accessible and organized to facilitate retrieval by either party. The facility failed to collaborate care and services with R17's hospice provider, which placed R17 at risk of impaired end-of-life care.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 37450 The facility had a census of 21 residents. Based on record review and interview the facility failed to submit complete and accurate staffing information through Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare and Medicaid Service (CMS) for Fiscal Year (YR) 2023 Quarter (Q) 4 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days (five). A review of the facility's licensed nurse timesheet data for the dates listed on the PBJ revealed a licensed nurse was on duty 24 hours a day seven days a week. On 11/18/24 at 12:26 PM, Administrative Staff A reported the discrepancy may be related to the submission of licensed nurse break hours and this had been adjusted to capture all the hours licensed nurses worked. Administrative Staff D stated the facility had nurse coverage 24 hours a day. The facility's undated Mandatory Submission of Uniform Format Staffing Information (PBJ) policy documented the facility would electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 26768 The facility had a census of 21 residents. Based on interviews and record review, the facility failed to implement a water management plan to mitigate risks for Legionella (a bacterium spread through the mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by Legionella). The facility failed to maintain an antibiotic tracking system and did not review its infection control policies annually. This deficient practice placed the 21 residents of the facility at risk for infection. Findings included: - The facility printed out a log that included resident names, locations, and prescriptions. The prescriptions were dated from 9/30/22 to 10/02/24. The log revealed eight prescriptions for antibiotics in 2024 but indicated the infection being treated was unknown. The log lacked documentation of onset, symptoms, or cultures. The facility's Infection Control policy was last reviewed on 07/01/21 and the facility's Vaccine policy was 02/13/23. The facility had Appendix A for Identifying Buildings at Increased Risk which indicated the facility should have a water management program for the hot and cold-water distribution system. On 11/19/24 at 01:55 PM, Administrative Staff A verified the facility had not reviewed the infection control policies annually, and that it had been a couple of years since they did. Administrative Staff A verified the facility had not followed through with setting up a water management program to address Legionella risk. On 11/20/24 at 09:55 AM, Administrative Staff D, the certified Infection Preventionist, verified the facility had not tracked infections and did not have an ongoing monitoring process in place. She stated the staff discussed any current infections during the Quality Assessment and Assurance meetings. On 11/20/24 at 09:55 AM, Administrative Staff E stated she checked for patterns if more than one infection was going on at a time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Antibiotic Stewardship policy, dated 07/15/2021, stated the center would discuss antibiotic use and resistance data. Compliance with antibiotic use algorithms and results of provider feedback during QAPI. The policy stated the Infection Preventionist would monitor antibiotic stewardship activities through a review of provider orders, clinical documentation, and pharmacy and lab reports. The ICP would track antibiotic use and resistance patterns, provide education as needed, and alert the facility if certain antibiotic-resistant organisms were identified. The policy stated the facility would implement a standard assessment and communication tool for residents suspected of having an infection SBAR. The facility would monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Monitor if cultures were obtained before antibiotics were initiated and if antibiotics changed during the course of treatment. The facility's Infection Control Policy dated 07/01/2021, stated the facility would establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility's Legionella Risk Management policy stated the facility would ensure appropriate precautions for the control of Legionella bacteria were identified through a Legionella risk assessment process and appropriate control measures implemented to ensure, as reasonably practicable, the health, safety, and welfare of residents. The minimum standards to be met included: Legionella risk assessments, a description of the building water system, and an identification of where Legionella could grow and spread. An action plan for preventing or controlling the risk. Implementation, management, monitoring, and recording of precautions. The facility failed to implement a water management plan to mitigate risk for Legionella and failed to maintain an antibiotic tracking system and review infection control policies at least annually. This placed the 21 residents of the facility at increased risk for infection.