STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175545	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Manor Nursing Center	403 S Valley Cunningham, KS 67035

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 41 residents. The sample included 12 residents. Based on record observation, record review, and interview, the facility failed to identify Resident (R) 32's multiple unwitnessed falls with fractures as possible neglect and report to the State Agency (SA) as required. This placed the resident at risk for unidentified and/or ongoing abuse. Finding included: - R32's Electronic Medical Record (EMR) included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), major depressive disorder (major mood disorder which causes persistent feelings of sadness) with severe psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms, generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and nondisplaced intertrochanteric (upper portion of thigh bone) fracture of left femur (thigh bone). R32's Quarterly Minimum Data Set (MDS), dated [DATE], documented that staff assessed the resident with moderately impaired cognition; R32 had no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by gross impairment in reality perception), or behaviors exhibited. R32 had a functional range of motion impairment on the lower extremity on one side and used a wheelchair. The MDS further documented R32 as dependent on staff for toileting, bathing, personal hygiene, dressing lower body dressing, putting on and taking off footwear, and mobility. R32 was incontinent of urine and bowel. The MDS recorded R32 had nonverbal indicators of pain and received scheduled pain medication. R32 had one fall with a major injury, and a recent surgery requiring active Skilled Nursing Facility (SNF) services for a repaired fracture of the pelvis, hip, leg, knee, or ankle. The Fall Care Area assessment dated [DATE] documented R32 at increased risk for falls due to advancing Parkinson's disease and noted the resident tended to walk the halls and forgot to use a walker at times. The overall objective in care planning for falls was avoidance through minimization of risks such as ensuring proper footwear, ensuring clothes were clean, dry, and not wet with urine, and reminding R32 to use a walker. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's Care Plan, dated 09/20/22, documented R32 admitted from the home setting to Long Term Care (LTC) due to an increased need for assistance with personal care and increasingly unsteady gait resulting in multiple falls, all related to a diagnosis of Parkinson's disease. The care plan directed staff to frequently monitor R32's whereabouts, monitor R32 when ambulating, and remind him to use his walker; if R32's gait appeared unsteady, ask him to sit down for a few minutes until he calmed down and could proceed safely. R32's Care Plan, dated 02/16/24, documented R32 had an increased risk for falls related to impetuous behavior. The care plan directed staff to place the resident's bed in a low position with assist rails, place a fall mat, use a soft touch call light, provide frequent monitoring of whereabouts, and R32 would attend physical and occupational therapy. The care plan further directed staff to transfer R32 with the assistance of two staff and utilize a wheelchair for mobility; R32 was toe-touch weight-bearing status. The care plan documented R32 was at risk for bleeding related to anticoagulation (a medication which prevents blood from clotting) medication and increased pain related to post-surgical hip repair. A review of R32's falls as documented in the EMR, and Fall Investigation Summary revealed the following: On 07/17/23 at 04:45 PM, staff found R32 on the floor of his room. R32 reported he tripped on the slippery floor. The occurrence was not witnessed. R32 had a decreased range of motion to his left arm and guarding towards his left shoulder. At 11:00 PM, R32 returned from the emergency room with a diagnosis of a fractured clavicle (collarbone) to the left side; R32 wore a sling. No corrective action was noted. The EMR and/or report lacked evidence the issue was identified as possible neglect and reported to the SA. On 09/24/23 at 11:41 AM R32 was found sitting on the floor with his back against the door of the dining room bathroom. The fall was not witnessed and R32 reported he was hurt all over though no injury was found. The Fall Investigation Summary documented R32 had an unwitnessed fall in the dining room bathroom area and was unable to say what happened. R32 often walked around on his own, looking for the bathroom, and became unsteady while walking. A corrective action documented staff were educated to be more aware when R32 was up and walking around and to assist and direct the resident to his bathroom. The care plan lacked the corrective action noted. The EMR and/or report lacked evidence the issue was identified as possible neglect and reported to the SA. On 03/12/24 at 07:54 PM, staff found him lying on his left side with a large bulge to his left thigh area, and he complained of left elbow, thigh, and hip pain. R32 transferred himself from the wheelchair without the brakes on and with the wheelchair footrest in the way at the time of the fall. R32 took an anticoagulant and needed to be transferred to the hospital. The Interdisciplinary Team Review Investigation documented R32 had severe cognitive impairment and was found on the floor after an unwitnessed event. The suspected root cause was while staff got R32 ready for bed, staff stepped out of his room to get help to transfer him, and R32 attempted to transfer himself. The investigation recommended an intervention to educate staff that the resident was not to be left alone in his room when he was in a wheelchair. The care plan lacked recommendations for intervention. The EMR and/or report lacked evidence the issue was identified as possible neglect and reported to the SA. The Progress Note dated 03/13/24, recorded R32 had a second surgical repair to his left hip. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 02:40 PM observation revealed R32 in his room in bed and covered with blankets. R32 yelled out for assistance and tried to get out of bed. Staff responded and took R32 to the commons area and assisted him to a recliner between the nurses' station and dining room. On 04/04/24 at 12:53 PM Administrative Staff A stated he had not reported R32's unwitnessed falls with major injury injuries because he felt there was no neglect or abuse. The facility's Abuse, Neglect and Exploitation policy, dated 11/15/23, documented the facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. Possible indicators of abuse include but are not limited to physical injury of a resident of unknown source. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. Reporting of all alleged violations to the Administrator, SA, adult protective services, and all other required agencies within a specific timeframe: Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation don not involve abuse and do not result in serious bodily injury. The facility failed to identify R32's multiple unwitnessed falls which resulted in fractures as potential neglect and report to the SA as required. This placed R32 at risk for unidentified and/or ongoing abuse or neglect.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41713 The facility identified a census of 41 residents. The sample included 12 residents with two residents sampled for hospitalization and one resident sampled for discharge. Based on observation, record review, and interview, the facility failed to provide written notice of transfer as soon as practicable to Resident (R) 13 or their representative for their facility-initiated transfers and/or discharge. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R13. Findings included: - The electronic medical record for R13 documented diagnosis of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), hypertension (HTN- elevated blood pressure), and sepsis (a life-threatening systemic reaction that develops due to infections which cause inflammation throughout the entire body). R13's Annual Minimum Data Set (MDS) dated [DATE] documented R13 had a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. R13 required substantial/maximal assistance and was dependent on staff for all her activities of daily living (ADLs). R13's Discharge MDS dated [DATE] had been initiated but was incomplete. R13's Falls Care Area Assessment (CAA) dated 01/15/24 documented R13 had a moderated cognitive impairment and had poor safety awareness. R13 had a history of falls and was dependent on staff for transfers and most daily care. R13 usually understood conversations and could usually make needs known. R13's Care Plan last revised 03/11/24 lacked staff direction regarding discharge. A Nurses Note dated 03/16/24 at 11:28 PM documented under the Progress Notes tab of the EMR recorded that frank blood was noted when R13 was changed at 10:42 PM. R13 was assessed by the nurse and a golf ball sized amount of blood was noted in R13's brief. The nurse obtained R13's vital signs. At 10:48 PM the hospital was called, and an order was received from the on-call physician to send R13 to the emergency department. A Clinical Admission note in the Progress Notes tab of the EMR dated 03/20/24 at 02:14 PM documented R13 arrived back at the facility by way of the facility van. The facility provided a signed Private Pay Bed Hold Authorization form dated and signed by R13's representative on 03/17/24 for R13's discharge to the hospital on 03/17/24. The facility was unable to provide as requested the required written notification of transfer/discharge for R13's discharge to the hospital on 03/17/24. On 04/02/24 at 12:35 PM, R13 sat at the dining table along with other residents eating her lunch. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 03:05 PM Social Services X stated she did complete the bed holds and notified the ombudsman when a resident was transferred out of the facility or was discharged . Social Services X stated she did not deal with the transfer or discharge paperwork, but the family was notified by phone call when a resident was sent out of the facility to the hospital. On 04/03/24 at 03:08 PM Administrative Nurse D stated a bed hold policy was given to the resident and their representative when the form was signed. Administrative Nurse D stated a phone call was made to the resident's representative when a resident was transferred out of the facility for any reason, but no written form of transfer or discharge was provided to the resident or their representative that she was aware of. The undated facility policy Transfer and Discharge documented the facility's transfer/discharge notice would be provided to the resident and the resident's representative in a language and manner which they could understand. The notice would include the following at the time it was provided: The specific reason and basis for transfer and discharge. The effective date of transfer or discharge. The specific location to which the resident was to be transferred -or discharged . An explanation of the right to appeal the transfer or discharge to the State. The notice must be provided to the resident, the resident's representative if appropriate, and the LTC ombudsman as soon as practicable. The facility failed to provide written notice of transfer as soon as practicable to R13 or their representative for their facility-initiated transfers. This deficient practice had the risk of miscommunication between the facility and resident/family and possible missed opportunity for healthcare service for R13.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to revise the care plan with effective interventions for Resident (R) 32 and R22 who had falls with injuries. This placed R32 and R22 at risk for ongoing falls and injury due to uncommunicated care needs. Findings included: - R32's Electronic Medical Record (EMR) included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), major depressive disorder (major mood disorder which causes persistent feelings of sadness) with severe psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms, generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and nondisplaced intertrochanteric (upper portion of thigh bone) fracture of left femur (thigh bone). R32's Quarterly Minimum Data Set (MDS), dated [DATE], documented staff assessed the resident with moderately impaired cognition; R32 had no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by gross impairment in reality perception), or behaviors exhibited. R32 had a functional range of motion impairment on the lower extremity on one side and used a wheelchair. The MDS further documented R32 as dependent on staff for toileting, bathing, personal hygiene, dressing lower body dressing, putting on and taking off footwear, and mobility. R32 was incontinent of urine and bowel. The MDS recorded R32 had nonverbal indicators of pain and received scheduled pain medication. R32 had one fall with a major injury, and a recent surgery requiring active Skilled Nursing Facility (SNF) services for a repaired fracture of the pelvis, hip, leg, knee, or ankle. The Fall Care Area assessment dated [DATE] documented R32 at increased risk for falls due to advancing Parkinson's disease and noted the resident tended to walk the halls and forgot to use a walker at times. The overall objective in care planning for falls was avoidance through minimization of risks such as ensuring proper footwear, ensuring clothes were clean, dry, and not wet with urine, and reminding R32 to use a walker. R32's Care Plan, dated 09/20/22, documented R32 admitted from the home setting to Long Term Care (LTC) due to an increased need for assistance with personal care and increasingly unsteady gait resulting in multiple falls, all related to a diagnosis of Parkinson's disease. The care plan directed staff to frequently monitor R32's whereabouts, monitor R32 when ambulating, and remind him to use his walker; if R32's gait appeared unsteady, ask him to sit down for a few minutes until he calmed down and could proceed safely. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's Care Plan, dated 02/16/24, documented R32 had an increased risk for falls related to impetuous behavior. The care plan directed staff to place the resident's bed in a low position with assist rails, place a fall mat, use a soft touch call light, provide frequent monitoring of whereabouts, and R32 would attend physical and occupational therapy. The care plan further directed staff to transfer R32 with the assistance of two staff and utilize a wheelchair for mobility; R32 was toe-touch weight-bearing status. The care plan documented R32 was at risk for bleeding related to anticoagulation (a medication which prevents blood from clotting) medication and increased pain related to post-surgical hip repair. A review of R32's falls as documented from the EMR, and Fall Investigation Summary revealed the following: On 07/08/23 at 05:05 PM, R32 hollered from his room and reported he slowly rolled out of bed, trying to use the toilet. R32 stated he had pain on the right side down where the ribs ended. The Fall Investigation Summary recorded a corrective action of staff education to assist the resident to the toilet after meals. On 07/12/23 at 04:10 AM staff heard R32 hollering and found him in his room next to the bed. The fall was not witnessed and R32 reported he was going from his chair to his bed. R32 reported pain in his back and right hip. R32 went to the emergency room and the x-ray showed there was no fracture. The Fall Investigation Summary documented R32 had a recent antipsychotic (class of medications used to treat major mental conditions that cause a break from reality) decrease and orders to receive therapy services. The summary documented R32 had three falls in the past two weeks, and he reported the floor was slick. Staff mopped the floor and notified housekeeping to further clean the room. R32 had not been evaluated by therapy. The investigation documented nursing spoke to the therapists and asked them to evaluate R32 as soon as possible. On 07/17/23 at 04:45 PM, staff found R32 on the floor of his room. R32 reported he tripped on the slippery floor. The occurrence was not witnessed. R32 had a decreased range of motion to his left arm and guarding towards his left shoulder. At 11:00 PM, R32 returned from the emergency room with a diagnosis of a fractured clavicle (collarbone) to the left side; R32 wore a sling. No corrective action was noted. On 07/28/23 at 10:00 PM, R32 was in the dining room and tried to ambulate without his walker. R32 leaned to his left side and lost balance. The Fall Investigation Summary documented R32 had been restless and was toileted and redirected several times. The summary further documented R32's family member was concerned about his recent falls. A corrective action documented that staff were educated to direct R32 to a chair that would be more appropriate, easier to get out of, and better for staff to monitor the resident to assist him in getting up due to his not asking for help. The care plan lacked the corrective action noted. On 08/17/23 at 01:10 AM R32 had an unwitnessed fall with complaints of neck and head pain and went to the emergency room . The Fall Investigation Summary documented R32 was found outside of the bathroom. His pants were wet on the floor, and he stated he was going to the bathroom. A corrective action documented that staff were educated to check, change, and toilet R32 on all rounds through the night. The summary documented rounds occurred at 11:00 PM, 01:00 AM, 03:00 AM, and 05:00 PM. The care plan lacked the corrective action noted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/23 at 11:41 AM R32 was found sitting on the floor with his back against the door of the dining room bathroom. The fall was not witnessed and R32 reported he was hurt all over though no injury was found. The Fall Investigation Summary documented R32 had an unwitnessed fall in the dining room bathroom area and was unable to say what happened. R32 often walked around on his own, looking for the bathroom, and became unsteady while walking. A corrective action documented staff were educated to be more aware when R32 was up and walking around and to assist and direct the resident to his bathroom. The care plan lacked the corrective action noted. On 10/26/23 at 08:15 PM, R32 had an unwitnessed fall after he attempted to self-toilet and reported right elbow pain. R32 reported he was going to the bathroom due to being incontinent in his brief. The Fall Investigation Summary documented the fall was not witnessed. R32 was weak and had an unsteady gait possibly related to his COVID-19 (highly contagious respiratory virus) diagnosis. A corrective action documented the resident was weak and would need therapy services when he was out of quarantine. On 01/05/24 at 03:00 AM R32 had an unwitnessed fall in his room while he was reaching for personal items. He was incontinent at the time of the fall. R32 had recent medication changes related to antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medications. R32 had vocal complaints of right and left knee pain. The Fall Investigative Summary documented R32 was found lying on his back in his room and stated he was looking for a phone book. R32 had socks on. A corrective action documented that staff were directed to ensure R32 had non-skid socks on when in bed. The care plan lacked the corrective action noted. On 02/12/24 at 01:01 PM, R32 had a fall that was witnessed by another resident. R32 was getting up and transferring from the table. R32 complained of left hip and elbow pain and went to the emergency room . The Fall Investigation Summary documented R32 sat at a table drinking juice and another resident witnessed R32 stand and fall to the left side onto the floor. R32 complained of left hip and elbow pain, and staff sent him to the emergency room . R32 had a left hip fracture and left elbow contusion. A corrective action documented R32 was to work with therapy when he returned from the hospital. On 03/12/24 at 07:54 PM, staff found him lying on his left side with a large bulge to his left thigh area, and he complained of left elbow, thigh, and hip pain. R32 transferred himself from the wheelchair without the brakes on and with the wheelchair footrest in the way at the time of the fall. R32 took an anticoagulant and needed to be transferred to the hospital. The Interdisciplinary Team Review Investigation documented R32 had severe cognitive impairment and was found on the floor after an unwitnessed event. The suspected root cause was while staff got R32 ready for bed, staff stepped out of his room to get help to transfer him, and R32 attempted to transfer himself. The investigation recommended an intervention to educate staff that the resident was not to be left alone in his room when he was in a wheelchair. The care plan lacked recommendations for intervention. The Progress Note dated 03/13/24, recorded R32 had a second surgical repair to his left hip. R32's Baseline Care Plan, dated 03/19/24 after readmission to the facility documented on return to the facility R32 had additional diagnoses of left basilar (lower lung area) infiltration and acute toxic metabolic encephalopathy (a broad term for any brain disease that alters brain function or structure). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 02:40 PM observation revealed R32 in his room in bed and covered with blankets. R32 yelled out for assistance and tried to get out of bed. Staff responded and took R32 to the commons area and assisted him to a recliner between the nurses' station and dining room. On 04/03/24 at 01:12 PM Certified Medication Aide (CMA) R along with Certified Nurse Aide (CNA) M assisted R32 from his wheelchair to his bed without bearing weight on the resident's left leg. R32's brief was changed due to urine incontinence. CMA R stated R32 was ambulatory and confused when he was admitted to the facility, and he had Parkinson's disease. CMA R said to prevent falls, staff assisted R32 with activities. CMA R said R32 was generally cooperative. CMA R said R32 would occasionally inform staff if he needed to have a bowel movement or be toileted, but otherwise, R32 was on a two-hour toileting schedule; he used a fall mat, had his bed in the lowest position, and should be checked frequently. On 04/04/24 at 09:30 AM, CNA N stated staff made sure R32 had his call light in reach, used a gait belt for transfers, and checked him frequently. CNA N said staff put R32's bed in the lowest position with a fall mat next to the bed, changed from wheelchair sitting to using a recliner, and staff toileted him before and after meals and during rounds. CNA N reported staff used verbal communication that to inform staff when residents fell , and staff checked the care plan in the nurses' station for any fall interventions. On 04/04/24 at 09:32 AM, Licensed Nurse (LN) G reported staff were informed during the shift report about falls and looked at the working care plan for interventions. On 04/04/24 at 11:29 AM Administrative Nurse D verified the resident had repeated falls, which resulted in fractures, and confirmed the resident's care plan was not updated with interventions by the Interdisciplinary Team (IDT) to prevent further falls. The facility's Resident Centered Care Plan Process dated 03/28/18, documented that care, treatment, and services are planned and provided to each resident in an interdisciplinary, comprehensive, and collaborative manner to ensure that all interventions are appropriate to the needs of the resident. Care planning will be implemented through the integration of assessment of findings, consideration of prescribed treatment plan, and development of goals of the resident that are reasonable and measurable. This will be considered a working care plan and will be kept on paper at the nurse's desk to document daily changes or updates to the plan of care. It is the responsibility of every member of the Interdisciplinary Team (IDT) to read, understand, and follow the comprehensive, person-centered care plan and to report any changes, no matter how slight or significant to the IDT for immediate care plan revision. The facility failed to revise the care plan with interventions to prevent falls for R32. This placed R32 at risk for further falls related to uncommunicated care needs. 41713 - The electronic medical record for R22 documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), and benign paroxysmal positional vertigo (BPPV- brief episodes of mild to intense dizziness after a change in head position). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R22 required partial to moderate assistance with activities of daily living (ADLS). R22 had no history of falls before admission. R22's Quarterly MDS dated [DATE] documented a BIMS score of 15 which indicated intact cognition. R22 required supervision with transfers from a chair and walking. R22 used a walker to assist with mobility. R22 had one fall without injury and one fall with injury since the prior assessment. R22's ADL Care Area Assessment (CAA) dated 09/11/23 documented she was working with therapy to regain strength and improve balance and gait while avoiding complications such as falls. R22's Fall CAA dated 09/11/23 documented that R22 had an unsteady gait and poor balance. The plan was to minimize the risks and avoidance of complications such as injuries related to falls. R22's Care Plan last updated 04/01/24 directed staff that R22 required stand-by assist staff with transfers and walking. R22 was independent with walking in her room. R22's care plan lacked interventions directing staff regarding falls. A fall investigation dated 10/11/23 documented R22 had an unwitnessed fall without injury in her room. R22 was found on the floor next to her bed by a staff member. Staff discussed the importance of a night light with the resident and advised R22 that her bathroom light could be left on, and the door cracked to allow light in. The investigation lacked a root cause analysis. A fall investigation dated 11/12/23 documented R22 had an unwitnessed fall that resulted in a hematoma to the back of her head. R22 was found on the floor in her room in front of her recliner; she had no bottom garments or shoes on. R22 stated she got up to go to the bathroom and was leaving the bathroom to find some pull-ups and slipped and fell . R22 was assessed by the nurse, and staff notified the physician and daughter of the incident. The fall investigation lacked a root cause analysis and new fall intervention. A fall investigation dated 11/27/23 documented R22 had an unwitnessed fall without injuries in her room. R22 was calling out for help and was found on the floor next to her bed. R22 stated there were kidnappers in her room. R22 was confused. R22 complained of pain in her left knee. The nurse completed a thorough assessment and obtained vital signs. R22 was returned to bed with assistance from three staff. Staff notified R22's physician and family. The physician ordered a urinalysis (lab analysis of urine). The fall investigation lacked a root cause analysis or new fall intervention. A fall investigation dated 12/04/23 at 03:15 AM documented R22 was found in her room on the floor next to her bed by staff. R22 complained of pain in her back after she hit it on her bed when she fell . The nurse came to assist and assess the resident. R22 stated she wanted to get up to her chair, so she stood, took a few steps, and fell . Staff notified R22's representative of the fall. The investigation noted the resident has had increased confusion and a decline in mobility. Staff notified the physician and received orders for a urinalysis and lab draw. The investigation lacked a root cause analysis and an update to the care plan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Manor Nursing Center	403 S Valley Cunningham, KS 67035

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall investigation dated 12/04/23 at 01:30 PM documented R22 had an unwitnessed fall in her room that resulted in a skin tear to her right elbow. R22 was found on the floor by the medication aide on her right side near her bathroom. R22's walker was tipped over. R22 was assessed by the nurse and the physician was notified. Staff received an order to send R22 to be evaluated at the emergency room (ER). R22 stated she got up to get ready for her appointment. R22's representative was notified and voiced concern about R22's recent decline. R22's room was moved closer to the nurse station. R22's ER visit showed R22 had a urinary tract infection (UTI-an infection in any part of the urinary system). The investigation lacked a root cause analysis and an update to the care plan. On 04/02/24 R22 walked with her walker to the dining room with a slow unsteady gait. On 04/04/24 at 09:42 Administrative Nurse F stated she was responsible for updating the care plans after the MDS was completed, but all nurses were able to update the care plan as needed after a fall or anything like that. On 04/04/24 at 12:13 AM Administrative Nurse D stated she was not aware that R22's care plan had not been updated with the new interventions put in place for R22 after her falls. Administrative Nurse D stated she would speak with staff to educate them and ensure that fall interventions were added to R22's care plan. The Resident Centered Care Plan Process policy last updated 03/28/18 documented at 90-day intervals, or more frequently based on the response to the resident's condition the interdisciplinary team would evaluate the resident's progress toward meeting the goals of care, treatment, and services. Revise the plan for care, treatment, and services. Collaborate with the resident and representative and family in reviewing and revising the plan for care, treatment, and services. The resident had the right to request revisions to their plan of care. The MDS/Care Plan Coordinator would serve as the coordinator for the care planning process. The interdisciplinary team would collaborate on the review and revision of the plan for care, treatment, and services. The facility failed to revise R22's Care Plan with interventions to prevent further falls. This deficient practice placed R22 at risk of further falls due to uncommunicated care needs.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 41 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to identify causal factors for falls, provide adequate supervision, and implement effective interventions to prevent avoidable accidents for Resident R (32) when he had multiple falls over various dates, which resulted in fractures, contusions, increased pain, and multiple trips to the hospital. The facility also failed to identify causal factors and implement interventions to prevent falls for R22. These failures caused actual harm to R32 and placed R22 and other residents at risk for continued accidents and injuries. Findings included: - R32's Electronic Medical Record (EMR) included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), major depressive disorder (major mood disorder which causes persistent feelings of sadness) with severe psychotic (any major mental disorder characterized by a gross impairment in reality perception) symptoms, generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, and nondisplaced intertrochanteric (upper portion of thigh bone) fracture of left femur (thigh bone). R32's Quarterly Minimum Data Set (MDS), dated [DATE], documented staff assessed the resident with moderately impaired cognition; R32 had no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by gross impairment in reality perception), or behaviors exhibited. R32 had a functional range of motion impairment on the lower extremity on one side and used a wheelchair. The MDS further documented R32 as dependent on staff for toileting, bathing, personal hygiene, dressing lower body dressing, putting on and taking off footwear, and mobility. R32 was incontinent of urine and bowel. The MDS recorded R32 had nonverbal indicators of pain and received scheduled pain medication. R32 had one fall with a major injury, and a recent surgery requiring active Skilled Nursing Facility (SNF) services for a repaired fracture of the pelvis, hip, leg, knee, or ankle. The Fall Care Area assessment dated [DATE] documented R32 at increased risk for falls due to advancing Parkinson's disease and noted the resident tended to walk the halls and forgot to use a walker at times. The overall objective in care planning for falls was avoidance through minimization of risks such as ensuring proper footwear, ensuring clothes were clean, dry, and not wet with urine, and reminding R32 to use a walker. R32's Care Plan, dated 09/20/22, documented R32 admitted from the home setting to Long Term Care (LTC) due to an increased need for assistance with personal care and increasingly unsteady gait resulting in multiple falls, all related to a diagnosis of Parkinson's disease. The care plan directed staff to frequently monitor R32's whereabouts, monitor R32 when ambulating, and remind him to use his walker; if R32's gait appeared unsteady, ask him to sit down for a few minutes until he calmed down and could proceed safely. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R32's Care Plan, dated 02/16/24, documented R32 had an increased risk for falls related to impetuous behavior. The care plan directed staff to place the resident's bed in a low position with assist rails, place a fall mat, use a soft touch call light, provide frequent monitoring of whereabouts, and R32 would attend physical and occupational therapy. The care plan further directed staff to transfer R32 with the assistance of two staff and utilize a wheelchair for mobility; R32 was toe-touch weight-bearing status. The care plan documented R32 was at risk for bleeding related to anticoagulation (a medication which prevents blood from clotting) medication and increased pain related to post-surgical hip repair. Review of R32's falls as documented from the EMR and Fall Investigation Summary revealed the following: On 07/08/23 at 05:05 PM, R32 hollered from his room and reported he slowly rolled out of bed, trying to use the toilet. R32 stated he had pain on the right side down where the ribs ended. The Fall Investigation Summary recorded a corrective action of staff education to assist the resident to the toilet after meals. On 07/12/23 at 04:10 AM staff heard R32 hollering and found him in his room next to the bed. The fall was not witnessed and R32 reported he was going from his chair to his bed. R32 reported pain in his back and right hip. R32 went to the emergency room and the x-ray showed there was no fracture. The Fall Investigation Summary documented R32 had a recent antipsychotic (class of medications used to treat major mental conditions that cause a break from reality) decrease and orders to receive therapy services. The summary documented R32 had three falls in the past two weeks, and he reported the floor was slick. Staff mopped the floor and notified housekeeping to further clean the room. R32 had not been evaluated by therapy. The investigation documented nursing spoke to the therapists and asked them to evaluate R32 as soon as possible. On 07/17/23 at 04:45 PM, staff found R32 on the floor of his room. R32 reported he tripped on the slippery floor. The occurrence was not witnessed. R32 had a decreased range of motion to his left arm and guarding towards his left shoulder. At 11:00 PM, R32 returned from the emergency room with a diagnosis of a fractured clavicle (collarbone) to the left side; R32 wore a sling. No corrective action noted. On 07/28/23 at 10:00 PM, R32 was in the dining room and tried to ambulate without his walker. R32 leaned to his left side and lost balance. The Fall Investigation Summary documented R32 had been restless and was toileted and redirected several times. The summary further documented R32's family member was concerned about his recent falls. A corrective action documented that staff were educated to direct R32 to a chair that would be more appropriate, easier to get out of, and better for staff to monitor the resident to assist him in getting up due to his not asking for help. The care plan lacked the corrective action noted. On 08/17/23 at 01:10 AM R32 had an unwitnessed fall with complaints of neck and head pain and went to the emergency room . The Fall Investigation Summary documented R32 was found outside of the bathroom. His pants were wet on the floor, and he stated he was going to the bathroom. A corrective action documented that staff were educated to check, change, and toilet R32 on all rounds through the night. The summary documented rounds occurred at 11:00 PM, 01:00 AM, 03:00 AM, and 05:00 PM. The care plan lacked the corrective action noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/24/23 at 11:41 AM R32 was found sitting on the floor with his back against the door of the dining room bathroom. The fall was not witnessed and R32 reported he was hurt all over though no injury was found. The Fall Investigation Summary documented R32 had an unwitnessed fall in the dining room bathroom area and was unable to say what happened. R32 often walked around on his own, looking for the bathroom, and became unsteady while walking. A corrective action documented staff were educated to be more aware when R32 was up and walking around and to assist and direct the resident to his bathroom. The care plan lacked the corrective action noted. On 10/26/23 at 08:15 PM, R32 had an unwitnessed fall after he attempted to self-toilet and reported right elbow pain. R32 reported he was going to the bathroom due to being incontinent in his brief. The Fall Investigation Summary documented the fall was not witnessed. R32 was weak and had an unsteady gait possibly related to his COVID-19 (highly contagious respiratory virus) diagnosis. A corrective action documented the resident was weak and would need therapy services when he was out of quarantine. On 01/05/24 at 03:00 AM R32 had an unwitnessed fall in his room while he was reaching for personal items. He was incontinent at the time of the fall. R32 had recent medication changes related to antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medications. R32 had vocal complaints of right and left knee pain. The Fall Investigative Summary documented R32 was found lying on his back in his room and stated he was looking for a phone book. R32 had socks on. A corrective action documented that staff were directed to ensure R32 had non-skid socks on when in bed. The care plan lacked the corrective action noted. On 02/12/24 at 01:01 PM, R32 had a fall that was witnessed by another resident. R32 was getting up and transferring from the table. R32 complained of left hip and elbow pain and went to the emergency room . The Fall Investigation Summary documented R32 sat at a table drinking juice and another resident witnessed R32 stand and fall to the left side onto the floor. R32 complained of left hip and elbow pain, and staff sent him to the emergency room . R32 had a left hip fracture and left elbow contusion. A corrective action documented R32 was to work with therapy when he returned from the hospital. On 03/12/24 at 07:54 PM, staff found him lying on his left side with a large bulge to his left thigh area, and he complained of left elbow, thigh, and hip pain. R32 transferred himself from the wheelchair without the brakes on , and with the wheelchair footrest in the way at the time of the fall. R32 took an anticoagulant and needed to be transferred to the hospital. The Interdisciplinary Team Review Investigation documented R32 had severe cognitive impairment and was found on the floor after an unwitnessed event. The suspected root cause was while staff got R32 ready for bed, staff stepped out of his room to get help to transfer him, and R32 attempted to transfer himself. The investigation recommended an intervention to educate staff that the resident was not to be left alone in his room when he was in a wheelchair. The care plan lacked recommendations for intervention. The Progress Note dated 03/13/24, recorded R32 had a second surgical repair to his left hip. R32's Baseline Care Plan, dated 03/19/24 after readmission to the facility documented on return to the facility R32 had additional diagnoses of left basilar (lower lung area) infiltration and acute toxic metabolic encephalopathy (a broad term for any brain disease that alters brain function or structure). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/03/24 at 02:40 PM observation revealed R32 in his room in bed and covered with blankets. R32 yelled out for assistance and tried to get out of bed. Staff responded and took R32 to the commons area and assisted him to a recliner between the nurses' station and dining room. On 04/03/24 at 01:12 PM Certified Medication Aide (CMA) R along with Certified Nurse Aide (CNA) M assisted R32 from his wheelchair to his bed without bearing weight on the resident's left leg. R32's brief was changed due to urine incontinence. CMA R stated R32 was ambulatory and confused when he was admitted to the facility, and he had Parkinson's disease. CMA R said to prevent falls, staff assisted R32 to activities. CMA R said R32 was generally cooperative. CMA R said R32 would occasionally inform staff if he needed to have a bowel movement or be toileted, but otherwise, R32 was on a two-hour toileting schedule; he used a fall mat, had his bed in the lowest position, and should be checked frequently. On 04/04/24 at 09:30 AM, CNA N stated staff made sure R32 had his call light in reach, used a gait belt for transfers, and checked him frequently. CNA N said staff put R32's bed in the lowest position with a fall mat next to the bed, changed from wheelchair sitting to using a recliner, and staff toileted him before and after meals and during rounds. CNA N reported staff used verbal communication that to inform staff when residents fell , and staff checked the care plan in the nurses' station for any fall interventions. On 04/04/24 at 09:32 AM, Licensed Nurse (LN) G reported when a fall occurred, the nurse assessed the resident for injuries and signs of change; they notified the physician, family, and administration. LN G completed fall charting and the report was given to the Director of Nursing. LN G said staff were informed during the shift report about falls and looked at the working care plan for interventions. On 04/04/24 at 11:29 AM Administrative Nurse D verified the resident had repeated falls, which resulted in fractures and confirmed the resident's care plan was not updated with interventions by the Interdisciplinary Team (IDT) to prevent further falls. The facility's Accident/Incident Committee policy, dated 11/20/20, is documented to review post-incident documentation to ensure that adequate interventions have been put in place to reduce the risk of future occurrences. The facility failed to provide adequate supervision, identify causal factors, and implement effective interventions to prevent R32 from multiple falls, which resulted in contusions, fractures, increased pain, and hospitalization s. These failures resulted in actual harm to R32 and placed the resident at risk for further falls with injuries. 41713 - The electronic medical record for R22 documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), glaucoma (abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), and benign paroxysmal positional vertigo (BPPV- brief episodes of mild to intense dizziness after a change in head position). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall investigation dated 12/04/23 at 01:30 PM documented R22 had an unwitnessed fall in her room that resulted in a skin tear to her right elbow. R22 was found on the floor by the medication aide on her right side near her bathroom. R22's walker was tipped over. R22 was assessed by the nurse and the physician was notified. Staff received an order to send R22 to be evaluated at the emergency room (ER). R22 stated she got up to get ready for her appointment. R22's representative was notified and voiced concern about R22's recent decline. R22's room was moved closer to the nurse station. R22's ER visit showed R22 had a urinary tract infection (UTI-an infection in any part of the urinary system). The investigation lacked a root cause analysis and an update to the care plan. On 04/02/24 R22 walked with her walker to the dining room with a slow unsteady gait. On 04/03/24 at 08:00 AM Licensed Nurse (LN) H stated when a resident had a fall typically the resident was assessed, an investigation was conducted, and witness statements were obtained by any witnesses. LN G stated then the interdisciplinary team (IDT) would meet and come up with a new intervention for the fall. On 04/04/24 at 09:04 AM Administrative Nurse D stated R22 has had a few falls recently. Administrative Nurse D stated after a fall the nurse would assess the resident, the physician and family would be notified, and then witness statements would be obtained so the IDT team could further investigate the incident. Administrative Nurse D stated the investigation includes finding the cause and coming up with new interventions to avoid further falls. The Accident/Incident Committee policy documented a meeting would be held within a reasonable timeframe with the Administrator, Director of Nursing (DON), Assistant DON, and any other pertinent department managers. The committee should meet where the incident occurred to visualize any environmental issues that may have led to the incident. The committee would review the incident report to ensure all areas were completed. The post-fall assessment would be reviewed. The care plan would be reviewed to ensure immediate interventions were put into place after the incident. The committee would complete and update the fall risk assessment. Any additional interventions that have been made to the resident's plan of care would be communicated to the direct care staff by the DON or designee. The log of the accidents and incidents would be taken to Quality Assurance and Performance Improvement (QAPI) for review. The facility failed to ensure staff completed a thorough fall investigation for R22 which included a root cause analysis for the fall and failed to identify and implement interventions to prevent further falls. This deficient practice places R22 at risk of further fall and possible injury.