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	12/30/2025

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 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. The facility reported a census of 36 residents. Based on observation, record review, and interview, the facility failed to ensure that meals were served at a safe and appetizing temperature.Findings included:- During an observation on 12/28/25 at 11:33 AM, Dietary CC prepared four servings of pureed fried chicken that had a cooked temperature of 195.6 degrees Fahrenheit (F). Once pureed, the chicken was scraped into a small metal container and placed in the steam table, uncovered. Continued observation at 11:57 AM revealed Dietary Staff CC rechecked the temperature of the pureed chicken in the steam table prior to serving, and the temperature was 132.7 degrees F. The chicken and other food items for this meal were served after all holding temperatures were checked. During an interview on 12/28/25 at 12:06 PM, Dietary Staff CC verified chicken should be served at 135 degrees F or higher, as it should have a holding temperature of 135 degrees F. Dietary Staff CC verified the pureed chicken was served at 132.7 degrees F. The facility did not provide a policy related to safe, appetizing food temperatures.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility reported a census of 36 residents. The sample included 12 residents. Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to a Resident (R) 3 with a feeding tube (tube for introducing high-calorie fluids into the stomach). The facility further failed to ensure adequate hand hygiene before and after personal care for R3, and R23. The facility failed to store nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask and oxygen nasal cannula in a sanitary manner for R30 and R1. Additionally, the facility failed to sanitize mechanical lift in-between residents' use. Furthermore, R23's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) tubing dragged on the ground.Findings included:- During an observation on 12/28/25 at 08:48 AM, R30's nebulizer mask laid directly on the nightstand table, which was attached to the medication chamber that had clear liquid identified. R30's oxygen nasal cannula was wrapped around R30's wheelchair handle. R30 reported she had a bag to place the nasal cannula in at one time. During an observation on 12/28/25 at 09:18 AM, R1's nebulizer mask laid unbagged on her bedside table. There was no date on R1's oxygen nasal cannula or nebulizer equipment. During an observation on 12/28/25 at 10:30 AM, no EBP signs were visible for residents who required EBP. Follow-up observation on 12/28/25 at 03:30 PM revealed EBP signs were placed on the door frames of residents who required EBP. During an observation on 12/29/25 at 08:08 AM, Certified Nurse Aide (CNA) P and CNA transferred R3, who had a feeding tube, with a mechanical lift from his bed to his recliner. CNA P and CNA Q lacked the required EBP personal protective equipment. CNA Q removed the mechanical lift from R3's room and pushed it into R12's room without sanitizing the lift. During an observation on 12/29/25 at 08:31 AM, CNA P and CNA Q placed R23's catheter drainage bag on the mechanical lift sling at R23's shoulder level. CNA Q removed the gown and gloves and, without performing hand hygiene, wheeled R23 to the dining area. CNA P cleaned up the room, removed the gown and gloves, and, without performing hand hygiene, exited R23's room with trash. CNA P returned the mechanical lift to the storage area without cleaning it. During an observation of 12/29/25 at 10:10 AM, R23 was in the therapy room with unidentified therapy personnel. R23's catheter tubing laid directly on the floor in front of the right front wheelchair wheel. The therapy staff positioned R23's wheelchair, which caused the wheelchair to roll over the catheter tubing. During an observation on 12/29/25 at 10:36 AM, Licensed Nurse (LN) G and Certified Medication Aide (CMA) R applied gowns and gloves prior to direct care for R3's tube feeding. LN G and CMA R did not wash their hands before applying the personal protective equipment (PPE). During an interview on 12/29/25 at 08:45 AM with CNA P and CNA Q, CNA P reported that R3's precautions changed for his skin tears. She said she did not see the EBP sign on R3's door frame that morning. CNA P confirmed that she had not applied a gown for R3's direct cares any morning until she was educated by Administrative Nurse E that morning, after she provided care to R3. CNA P reported that the only resident she knew who had EBP last week was R23. CNA Q reported that she did not wash off the mechanical lift between residents, and the sanitation wipes are at the nurse's station. During an interview on 12/29/25 at 08:51 AM, CNA P and CNA Q reported the EBP signs were hung up last week, and staff were notified of the change sometime that morning. CNA Q stated she had not been wearing gowns for direct cares for residents on EBP except for R23 prior to that day. CNA P and CNA Q reported they performed hand hygiene prior to applying and after they removed their PPE. During an interview on 12/29/25 at 10:55 AM, LN G reported the EBP sign was posted outside R3's door a couple of weeks ago. LN G reported that she expected the CNAs to wear all the PPE required for EBP and said they had been trained on EBP. LN G said she washed her hands prior to applying PPE. During an interview on 12/29/25 at 12:40 PM, Administrative Nurse E (Infection Preventionist Nurse) reported that the signs for EBP had all fallen (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down, and she had a hard time keeping them posted outside the residents' rooms. Administrative Nurse E indicated she needed some recommendations on how to keep the signs from falling. During an interview on 12/30/25 at 09:55 AM, Administrative Nurse E revealed she expected staff to wear appropriate PPE when providing direct care for residents on EBP and reported she has trained the staff numerous times. Administrative Nurse E reported she expected the catheter tubing not to touch the floor and drag across the floor, and she expected staff to place a catheter drainage bag below a resident's waist during a transfer. Administrative Nurse E reported she expected staff to sanitize the mechanical lift and shared medical equipment with the sanitation wipes between resident use. Additionally, she reported she expected the staff to perform hand hygiene prior to applying and removing PPE. The facility's Infection Control Policy dated 09/09/25 documented this facility would facilitate safe care of all residents and staff with known or suspected communicable diseases by establishing and maintaining an infection prevention and control program. Hand hygiene procedures are to be followed by staff involved in direct resident contact. If the use of common equipment or items is unavoidable, adequately clean and disinfect them before use for any other resident with a chemical agent. The facility did not provide a policy for EBP or catheter care.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. The facility reported a census of 36 residents; the sample included 12 residents sampled. Based on interviews and record review, the facility failed to ensure residents received the opportunity to participate in the care planning process when staff failed to invite Residents (R) 1 and R30 or their responsible party to care plan meetings.Findings included:1. R30's Electronic Medical Record (EMR) recorded a Quarterly Minimum Data Set (MDS) dated 08/25/25 and 11/25/25. R30's EMR lacked documentation of a care plan meeting conducted in the past six months. During an interview on 12/28/25 at 08:48 AM, R30 reported she was not invited to any care plan meeting. 2. R1's EMR recorded an admission MDS dated 11/03/25. R1's EMR lacked documentation of a care plan meeting conducted in the past two months. During an interview on 12/28/25 at 09:18 AM, R1said she did not know what a care plan meeting was and had not been invited to one since she was admitted two months ago. During an interview on 12/29/25 at 03:30 PM, Administrative Nurse F reported she invited the residents and the responsible party to the care plan meetings with a letter mailed to the responsible party, and a letter was also given to the resident at the facility. Administrative Nurse F reported she did not keep a copy of the letter and did not document in the EMR about invites to care plan meetings or when a care plan meeting was held. Administrative Nurse F reported a resident with a Brief Interview of Mental Status (BIMS) score of 12 or higher (indicating no cognitive impairment) could sign the care plan sheet at the end of the care plan in the book. Administrative Nurse F reported R30 had a BIMS of 13 and reported that she did not have a care plan sheet signed by R30 or the responsible party. Administrative Nurse F reported she did not have a signed care plan sheet for R1 and the responsible party, as R1's daughter had not been at the facility. During an interview on 12/30/25 at 01:04 PM, Administrative Nurse D revealed that residents at the facility do not go to care plan meetings. Administrative Nurse D said she was unsure whether families or residents had been invited to the care plan meetings and confirmed that no documentation existed to demonstrate families were invited to the care plan meetings. Administrative Nurse D reported she expected the care plan meetings to be held per facility policy. The facility's policy Resident Centered Care Plan Process dated 03/28/18, documented every reasonable effort will be made to accommodate the attendance of the resident and/or resident representative. If they are unable/unwilling to attend, documentation must be provided in the medical record of efforts made to accommodate attendance.

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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. The facility reported a census of 36 residents. The sample included 12 residents with one resident reviewed for self-administration of medications Based on observation, interview, and document review the facility failed to assess Resident (R) 30 for the ability to safely self-administer Mucinex (medication used to treat congestion) and Flonase (nasal spray to treat nasal congestion and allergies) and keep at the bedside. The facility additionally failed to ensure an order to keep those medications at the bedside and self-administer. Findings included:- R30 's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R30's 03/01/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. R30's MDS documented no behaviors and no depression. R30's MDS documented she required maximal assist with all activities of daily living (ADLs) except she required moderate assist for oral care, and she was independent with eating. R30's 03/03/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R30 triggered because she required assistance with ADLs. R30 was alert and oriented and was there for skilled services. R30's 12/28/25 Care Plan lacked documentation regarding self-administering medications. R30's Physician Orders documented budesonide inhalation suspension (a class of medication that works by decreasing swelling and irritation in the airways to make breathing easier). 0.5 milligram (mg)/2 milliliter (ml) 1 vial inhaled orally at bedtime for chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) may have it in the room for self-administration date ordered 03/24/25. R30's Physician Orders lacked an order for Mucinex and Flonase and lacked an order to keep at bedside for self-administration. R30's Self-Administration of Medication dated 02/25/25 at 03:15 PM documented R30 required assistance with storing medications in a secure location, opening and closing medication containers, and accurately telling time to know when medications would need to be taken. R30's Self-Administration of Medication dated 09/23/25 at 12:32 PM documented R30 was fully capable of storing medications in a secure location, opening and closing medication containers, and accurately telling time to know when medications would need to be taken. Physician approved R30 to have budesonide inhalation suspension in her room for self-administration. During an observation on 12/28/25 at 08:48 AM, R30 had a bottle of Mucinex 30 mg-600 mg tablets, extended release 12-hour, and Flonase on her bedside table. R30 reported she self-administered those medications on her own as she presently had a cold. During an interview on 12/29/25 at 01:30 PM, R30 reported that she was upset that Administrative Nurse D entered her room on 12/28/25 and took her bottle of cough syrup out of her room. R30 reported she put her bottle of Mucinex and Flonase away so staff would not take it. During an interview on 12/30/25 at 06:33 AM, Certified Medication Aide (CMA) U reported that residents were not allowed to have their own medications in their rooms. CMA U reported that if she did observe residents with medication in their room, she would remove the medications from the room and let the nurse know. During an interview on 12/30/25 at 11:49 AM, Licensed Nurse (LN) H reported that if any resident had any medications in their room, the resident would be assessed for self-administration, and it would be care planned. LN H confirmed that R30 had one self-administration assessment for budesonide, and nothing was noted for Mucinex and Flonase. During an interview on 12/30/25 at 01:04 PM, Administrative Nurse D reported R30 had a medicine cup of cough syrup on her table on 12/28/25 in the late afternoon, and the CMA had let her know. Administrative Nurse D reported she went to R30's room and asked her if she wanted to take her cough syrup, as it was not allowed to be left in her room, and she did not want to take it at that time, so R30 was educated that when she did want to take the medication, she could ask for it. Administrative Nurse D reported she removed the cough syrup from R30's room. Administrative Nurse (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D reported she did not see the Flonase or Mucinex in R30's room. The facility's policy Resident Self-Administration of Medication, dated 2025, documented it is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside that is not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or the responsible party.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. The facility had a census of 36 residents; the sample included 12 residents, including one resident reviewed for accommodation of needs. Based on observation, record review, and interview, the facility failed to ensure Resident (R)23's foot platform remain attached to her electric wheelchair. Findings included:- R23's Electronic Health Record (EHR) included diagnoses of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), chronic kidney disease (CKD - a long-term condition where the kidneys are damaged and cannot filter blood effectively), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities) and quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord). R23's 12/23/25 5-Day Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R23 was dependent on staff for all cares except eating, which required supervision/setup assistance. R23's Baseline Care Plan documented R23 utilized a manual wheelchair. During an observation on 12/28/25 at 01:19 PM, R23 sat in her electric wheelchair with her legs dangling unsupported from the seat of her electric wheelchair. During an interview on 12/28/25 at 01:19 PM, R23 revealed therapy staff had removed the foot platform from her wheelchair the day before, and nobody had reinstalled it. During an interview on 12/30/25 at 12:40 PM, Licensed Nurse (LN) H revealed residents who utilized electric wheelchairs should have the foot platform or pedals attached at all times to prevent the residents' legs from dangling, which would inhibit proper circulation. During an interview on 01/30/25 at 01:28 PM, Administrative Nurse D revealed residents with electric wheelchairs should have the foot platform or pedals attached all the time for safety concerns. The undated policy documented the facility would evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents is endangered. Further, the facility would make reasonable accommodations to individualize the resident's physical environment.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 36 residents; the sample included 12 residents. Based on observation, interview, and record review, the facility failed to obtain valid advanced directives (a legal document in which a person specified what actions should be taken for their health,) or assess the wishes of Resident (R) 23 related to end-of-life care.Findings included:- R23's Electronic Health Record (EHR) included diagnoses of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), chronic kidney disease (CKD - a long-term condition where the kidneys are damaged and cannot filter blood effectively), spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities) and quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord). R23's [DATE] 5-Day Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The assessment documented R23 was dependent on staff for all cares except eating which required supervision/setup assistance. R23's Baseline Care Plan documented R23 was a full code (a term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest). R23's EHR physician orders revealed an order for Full Code, effective [DATE]. During an interview on [DATE] at 01:57 PM R23 stated she had signed a do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire CPR in the event of cardiac arrest) document in the past and was able to describe potential injuries sustained during resuscitative efforts. She said she did not want to endure that pain or discomfort. R23 revealed facility staff had not asked her if she was a full code or had a DNR. During an interview on [DATE] at 12:40 PM Licensed Nurse (LN) H revealed when a new resident arrived at the facility, one of the nurses would complete several initial assessments that included asking the resident, or their representative, if the resident was a full code or had a DNR order. During an interview on [DATE] at 01:28 PM, Administrative Nurse D revealed the admitting nurse was responsible to confirm code status with the resident and/or their representative and request copies of the advanced directives if they existed. Administrative Nurse D stated that if a resident's code status was unknown, then an assessment was performed to obtain the information from the resident or their representative. The facility's undated Advance Directives policy documented it was the policy of the facility to recognize the right of residents and/or representatives to make informed decisions about medical care including the right to accept or refuse medical treatment and the right to formulate advance directives. Further, the facility would comply with applicable laws to promote and honor treatment preferences expressed by the resident or their representative. Every resident would be asked on admission if they have advance directives and would document discussions with the resident/representative. If the resident has an advance directive, the resident/representative would be asked to provide a copy which would become part of the resident's record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure a 14-day stop time for the use of an antidepressant (a class of medications used to treat mood disorders) for Resident (R) 5 on an as needed (PRN) basis, as required.Findings included:- Review of the Electronic Health Record (EHR) for R5 included diagnoses of Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dysphagia (difficulty swallowing) following cerebral infarction (stroke), dementia (a progressive mental disorder characterized by failing memory and confusion) and anxiety. R5's 02/21/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The assessment documented R5 received an antidepressant medication during the look-back period. R5's 11/17/25 Quarterly MDS documented a BIMS score of four, which indicated severely impaired cognition. The assessment documented R5 received an antidepressant medication during the look-back period. R5's 02/21/25 Psychotropic [affects mood or thoughts] Drug Use Care Area Assessment (CAA) documented R5 received Trazodone without any documented adverse reactions (unintended negative effect) or side effects. A consultant pharmacist reviewed the medications monthly for possible gradual dose reductions (GDR). R5's Care Plan reviewed 12/19/25, documented R5 utilized antidepressant medications related to anxiety, agitation, and depression. R5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 12/2025 documented the following:1. An order for Trazodone HCl oral tablet 50 milligrams (mg), give one-half tablet by mouth every 24 hours PRN insomnia (inability to sleep), give at bedtime (HS), dated 10/27/25. The order lacked a 14-day stop date. The order was discontinued on 12/09/25.2. An order for Trazodone HCl oral tablet 50 mg, give one tablet by mouth every 24 hours PRN insomnia; give at HS, dated 10/27/25. The order lacked a 14-day stop date. The order was discontinued on 12/09/25.3. An order for Trazodone HCl oral tablet 50 mg, give one-half tablet by mouth at bedtime for insomnia for 14 days, dated 12/09/25 and discontinued on 12/22/25. During an interview on 12/30/25 at 02:40 PM with Consultant GG and Administrative Staff A, Consultant GG outlined the medication regimen review process and stated the consultant pharmacist submitted his reports directly in the EHR. The facility would then print the recommendations and present them to the provider, then scan/fax the provider's responses back to the pharmacist as soon as possible. During an interview on 01/06/26 at 04:18 PM, Administrative Staff A revealed all psychotropic medications given on a PRN basis should have a 14-day stop time. If an order did slip through the checks that were in place, the pharmacist would address the concern on their next monthly medication regimen review. If the provider failed to add a stop time, then the pharmacist would call the provider directly and make an inquiry and request the provider provide a rationale for continued use beyond the 14-day period or to add a 14-day stop date to the order. The facility's undated Unnecessary Drugs - Without Adequate Indication for Use policy did not address the required 14-day stop time for PRN psychotropic medication use. The facility's policy Use of Psychotropic Medication(s), undated, documented the intent of the policy is to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. The facility had a census of 36 residents. The sample included 12 residents. Based on interview, observation, and record review, the facility failed to provide services to meet professional standards of care when staff failed to ensure Resident (R) 4's Electronic Medical Record (EMR) contained appropriate documentation for the paranoid schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) diagnosis. Findings included:- R4 's EMR revealed diagnoses of paranoid schizophrenia and dementia (a progressive mental disorder characterized by failing memory and confusion). R4's 04/29/25 Significant Change Data Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. R4's MDS revealed a diagnosis of schizophrenia. R4's 04/30/25/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R4 was oriented to herself only. R4's diagnoses were dementia and paranoid schizophrenia. R4 had her own form of communication, which staff have learned to understand. R4 was able to communicate needs in her own way. She would have periods of agitation and relied on reminders to use her rosary beads and prayer. R4's 12/28/25 Care Plan lacked documentation regarding schizophrenia. R4's 07/09/15 History and Physical lacked paranoid schizophrenia as a diagnosis. R4's 08/11/16 Physician Visit Note documented no paranoia. The note lacked paranoid schizophrenia as a diagnosis. R4's 12/20/19 Physician Visit Note documented a change in the diagnosis of risperidone (an antipsychotic, a class of medications used to treat major mental conditions that cause a break from reality) to paranoid schizophrenia. R4's 04/09/24 at 03:30 PM Physician Visit Note documented a diagnosis of paranoid schizophrenia. R4's 09/07/25 Psychotropic Medication Informed Consent documented the reason for use of medications, diagnosis of paranoid schizophrenia. R4's EMR lacked physician documentation, clinical findings, and assessments supporting the addition of the schizophrenia diagnosis. During an observation on 12/28/25 at 08:35 AM, R4 sat in her chair in her room; she had visible facial hair stubble around the jawline, chin, and upper lip. R4's fingernails were long and broken. R4 was repetitive with her words, repeating numbers as she swayed back and forth in her chair. During an interview on 12/30/25 at 11:49 AM, Licensed Nurse (LN) H reported that Administrative Nurse F documented all the residents' diagnoses in the EMR. During an interview on 12/30/25 at 03:47 PM, Administrative Nurse E reported that Administrative Nurse F was unavailable at that time and could not state why R4 had a diagnosis for paranoid schizophrenia in her diagnosis tab dated 04/09/24, which occurred during her stay at the facility. During an interview on 12/30/25 at 03:50 PM, Administrative Staff A revealed a Physician Visit Note dated 04/09/24 in the EMR that had paranoid schizophrenia as a diagnosis. Administrative Staff A reported that the physician received his information from a website with current diagnoses for the residents. During an interview on 12/30/25 at 04:15 PM, Administrative Staff A revealed a Physician Visit Note dated 12/20/19, which documented a change diagnosis of risperidone to paranoid schizophrenia. Administrative Staff A could not answer if R4 had a thoroughly documented history in her EMR for that diagnosis. Administrative Staff A reported he expected to have a thorough history documented for any resident with a new paranoid schizophrenia diagnosis. The facility did not provide a policy for professional standards of care in diagnosing schizophrenia for use with antipsychotics.

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	12/30/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. The facility reported a census of 36 residents. The sample included 12 residents with three residents reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to offer and provide assistance with nail care and facial hair removal for Resident (R) 4.Findings included:- R4 's Electronic Medical Record (EMR) revealed diagnoses of paranoid schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), dementia (a progressive mental disorder characterized by failing memory and confusion) and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R4's 04/29/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R4's MDS documented she required maximal assistance with bathing and moderate assistance with personal hygiene. R4's 04/30/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) did not trigger. R4's 04/30/25 Cognitive Loss/Dementia CAA documented R4 was oriented to the person. R4's diagnoses were dementia and paranoid schizophrenia. R4 had her own form of communication, which staff have learned to understand. R4 was able to communicate needs in her own way. She would have periods of agitation and relied on reminders to use her rosary beads and prayer. R4's Care Plan revised date 06/13/24 directed staff the nurse would trim her fingernails during the weekly skin assessment and as needed. The plan directed staff to cleanse R4's fingernails on bath days and as needed, and staff were to notify the nurse if her nails needed a trim, as she was diabetic. R4's Care Plan revised date 10/23/25 directed staff to assist R4 to maintain a clean, neat, well-groomed appearance and be free of body odor daily. Staff were instructed to shave her chin if needed. During an observation on 12/28/25 at 08:35 AM, R4 sat in her chair in her room. She had visible facial hair stubble around the jawline, chin, and upper lip. R4's fingernails were long and broken. R4 was repetitive with her words, repeating numbers as she swayed back and forth in her chair. During an observation on 12/29/25 at 07:47 AM, R4 sat in a chair in the dining room, eating her breakfast. R4 had visible facial hair stubble around the jawline, chin, and upper lip. R4's fingernails were long and broken. During an observation on 12/30/25 at 07:30 AM, R4 ambulated in the hallway to the dining room with her walker. R4 was clean-shaven, but her nails were unchanged from the 12/28/25 and 12/29/25 observations. During an interview on 12/30/25 at 09:15 AM, Certified Nurse Aide (CNA) N reported that she would shave a resident if they asked and or if she noted the resident needed a shave, she would assist the resident. CNA N reported that CNA M and CNA O completed the showers and whirlpool baths. During an interview on 12/30/25 at 09:20 AM, CNA O reported that she would shave residents on their bath days, and R4 was shaved that day as she received a bath. CNA O reported that R4's facial hair grew quite fast and said she probably should be shaved more than twice a week because she would get stubble very quickly. CNA O reported she could not cut fingernails for diabetic residents and confirmed that R4 could use a nail trimmer. CNA O said R4 was a diabetic, and she was worried she might nick the resident's skin. During an interview on 12/30/25 at 10:38 AM, CNA M reported she would shave residents on their shower days, whether they were diabetic or not. CNA M reported she would write the need for nails to be trimmed by the nurse on the shower sheet that she submitted to the nurse. CNA M then changed her statement, stating she would verbally alert the nurse if a resident who was diabetic required their fingernails to be trimmed. During an interview on 12/30/25 at 11:49 AM, Licensed Nurse (LN) H stated she expected the CNAs to shave the residents who required assistance. LN H reported the CNAs would verbally notify the nurse when a diabetic resident needed their fingernails clipped. During an interview on 12/30/25 at 01:04 PM, Administrative Nurse D revealed she expected the staff to shave residents every shower day or as needed. Administrative Nurse D said she expected the nurses to cut the diabetic residents' fingernails, and the CNAs would let the nurse know when that was needed. The facility's policy Activities of Daily Living (ADLs) dated (continued on next page)

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	175545	A. Building B. Wing	12/30/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025 documented the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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	175545	A. Building B. Wing	12/30/2025

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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. The facility reported a census of 36 residents; the sample included 12 residents with three residents reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to ensure an environment free from accident hazards when staff failed to support the feet of two residents, Resident (R) 5 and R31, off the ground during staff-assisted wheelchair locomotion.Findings included: - During an observation on 12/28/25 at 12:56 PM, R5 was in the common area and sat in her wheelchair without foot pedals attached. She was slumped forward and appeared to be asleep. Certified Nurse Aide (CNA) T pushed R5's wheelchair from the common area, down the hall, and into R5's room. R5's feet were touching the floor while CNA T pushed R5's wheelchair. During an observation on 12/28/25 at 04:35 PM, R31 sat in her wheelchair in the common area and sat in her wheelchair without foot pedals attached. Licensed Nurse (LN) H assisted R31 from the common area and partway down the hallway. R31 held her feet up while LN H assisted with wheelchair locomotion. During an observation on 12/29/25 at 01:40 PM, R31 sat in the activity area in her wheelchair without foot pedals attached. Activity Z assisted R31 out of the activity area and partway down the hallway, with R31 holding her feet off the floor during the assisted locomotion. During an interview on 12/30/25 at 11:55 AM, CNA S revealed residents in wheelchairs should have the pedals attached to the chair and feet secured on the pedals if staff is assisting with wheelchair locomotion. During an interview on 12/30/25 at 12:18 PM, Certified Medication Aide (CMA) R revealed if a resident was self-propelling in their wheelchair without pedals, staff should go get some pedals before providing assistance. CMA R said residents should always have wheelchair pedals attached and their feet properly secured on the pedals prior to staff-assisted wheelchair locomotion. During an interview on 12/30/25 at 12:40 PM, LN H revealed residents in wheelchairs should not be assisted by staff unless the wheelchair had pedals and the resident's feet were securely placed on the pedals. LN H revealed that the facility maintained a stock of spare wheelchair pedals for use with residents whose wheelchairs do not have pedals or if staff cannot find the resident's pedals. During an interview on 12/30/25 at 01:28 PM, Administrative Nurse D revealed the facility's expectation was that staff should not assist residents in wheelchairs unless foot pedals were present. Staff should obtain and install appropriately fitting pedals to the wheelchair and appropriately secure the resident's feet on the pedals prior to providing wheelchair assistance. The facility's undated Incidents and Accidents policy did not address applying pedals to a wheelchair prior to staff-assisted wheelchair locomotion.