STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265597	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop at Blue River, The	10425 Chestnut Dr Kansas City, MO 64137

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a physician order for self-administration of medication at bedside and failed to evaluate and document the ability to self-administer medication for one sample resident (Resident #3) out of 12 sampled residents. The facility census was 137 residents. Review of the facility's policy titled Resident Self-Admin Meds Clinically Appropriate dated August 2020 showed: -If a resident desired to self-administer medications, an assessment was conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out the responsibility during the care planning process. -For residents who self-administer, the interdisciplinary team verified the resident's ability to self-administer medications by means of skill assessment conducted on a monthly basis or when there was a significant change in condition. -The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage were recorded in the resident's medical record on the care plan for each medication authorized for self-administration, the label would contain a notation that it may be self-administered. -If the resident demonstrated the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage would be conducted. -When the interdisciplinary team determined that the bedside or in-room storage of medications would be a safety risk to other residents, the medications of the residents permitted to self-administer would be stored in the central medication cart or medication room. 1. Review of Resident #3's face sheet showed he/she readmitted to the facility on [DATE] with the following diagnoses: -Insomnia (persistent problems falling and staying asleep) Due to Other Mental Disorder. -Scoliosis (abnormal lateral curvature of the spine). -Spondylosis (a general term for age-related wear and tear of the spinal discs). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER: Hilltop at Blue River, The		STREET ADDRESS, CITY, STATE, ZIP CODE: 10425 Chestnut Dr Kansas City, MO 64137	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Prospective Payment System (PPS) five-day Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) assessment dated [DATE] showed the resident was cognitively intact. Review of the resident's care plan dated 12/24/24 showed: -No focus or intervention related to self-administration of medications. -He/She received pain medications. Review of the resident's Physician Order Sheet dated January 2025 showed: -No order for the resident to be able to self-administer any medication. -An order for Melatonin (a sleep supplement) tablet three milligrams (mg), give two tablets by mouth at bedtime for Insomnia. -An order for Tylenol (Acetaminophen- used to treat pain and reduce fevers) tablet 325 mg, give two tablets by mouth every six hours as needed for pain. Observation on 1/9/25 at 10:56 A.M. of the resident's room showed: -A bottle of Melatonin 10 mg. -An empty bottle of Extra Strength Tylenol 500 mg. -Both bottles were in the bottom drawer of his/her nightstand. During an interview on 1/9/25 at 10:56 A.M. the resident said: -He/She thought a staff person came around and had him/her sign something related to his/her medications, but he/she was unsure of what it was. -The staff were not aware that he/she had medication stored in his/her room. -His/Her family gave him/her the medication. -He/She had taken the last of his/her Tylenol that day. During an interview on 1/9/25 at 12:27 P.M. Certified Medication Technician (CMT) A said: -He/She had previously found medications at the resident's bedside. -The staff had found pill bottles in his/her room previously and removed them. -The resident did not have an order to self-administer medications. -He/She did not think that the resident had any medications in his/her room at that point in time. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had an order for Tylenol 325 mg, take two for a total of 650 mg, as needed for pain. -He/She was unsure about the resident's dosage of Melatonin. -He/She had never seen the resident's family member before, so he/she was unsure if the he/she had brought medications to the resident in the past. -The resident should not have any medications at his/her bedside or stored in his/her room. -An assessment needed to be completed by the nurses and an order needed to be obtained in order for residents to keep medications at their bedside. -He/She did not think the resident would qualify as a candidate to have medications stored in his/her room. During an interview on 1/9/25 at 12:50 P.M. the Director of Nursing (DON) said: -The resident did not have a current order for the resident to keep any medications at bedside. -The resident did not have a current assessment for the resident to keep medication at bedside. -The resident should not have any medication stored in his/her room. -He/She was unaware that the resident had medications in his/her room until he/she had only just been told about them. During an interview on 1/9/25 at 1:33 P.M. the resident said: -He/She had taken the Tylenol that was in his/her room at least two times a day for the pain in his/her back. -He/She had taken two tablets of his/her Melatonin and what the facility gave him/her equaling 26 mg of Melatonin at night, every night since she has had the bottle of the Melatonin in his/her room. -He/She had been given the bottles of medication after he/she had gotten back from the hospital on [DATE]. During an interview on 1/9/25 at 1:38 A.M. Licensed Practical Nurse (LPN) A said: -The resident was not allowed to keep any medication at his/her bedside. -The resident would need to have a doctor's order to have medication stored at his/her bedside. -He/She was unsure if the resident had any medication stored in his/her room at that point in time. -He/She was unaware that medications had been taken out of the resident's room previously. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was unsure of how the resident could have received the bottles of medication to keep in his/her room. -He/She was unaware that the resident had been giving himself/herself extra doses of Tylenol and Melatonin. -The bottles of medication needed to be taken out of the resident's room. During an interview on 1/9/25 at 1:48 P.M. the DON said: -Residents who wanted to self-administer any medication needed to have an assessment completed. -The nurses were responsible for completing the self-administration assessment. -There is a form in the facility's electronic charting system that nurses can use to complete the assessment. -Residents were able to ask for an assessment to be completed if they wanted to keep any medications at their bedside. -He/She was responsible for ensuring the completion of self-administration assessments. -The resident had not expressed that he/she wanted to have any medications kept at his/her bedside. -If the resident had expressed that he/she wanted to keep medications at his/her bedside, then the facility would have informed the physician and completed an assessment. -He/She did not think the resident would be a candidate to keep medications at his/her bedside due to being non-compliant with other policies in the facility. During an interview on 1/10/25 at 12:17 P.M. the Psychiatric Nurse Practitioner (NP) said: -It was not appropriate for the resident to have medication at his/her bedside. -He/She expected the staff to watch the residents take all medication. -No resident should have medications at their bedside unless there is an assessment. -He/She did not believe that the facility let residents keep medications at their bedside. MO00247016