

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Hilltop at Blue River, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21003</b></p> <p>Based on observation, interview and record review, the facility failed to ensure an individualized activity plan that was goal directed and incorporated the interest and ability of two sampled residents with dementia (Resident #22 and #90) out of 29 sampled residents. The facility census was 140 residents.</p> <p>Record review of the facility Activity policy and procedure dated 6/2020, showed:</p> <ul style="list-style-type: none"> <li>-The purpose was to encourage residents to participate in activities to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional functioning.</li> <li>-The facility provides and activity program designed to meet the needs, interests and preferences of residents.</li> <li>-The activities are varied and work to address the needs and interests identified through the assessment process.</li> <li>-Activities are developed for individual, small group and large group participation.</li> <li>-The interdisciplinary team evaluates the activity assessment and considers the resident's medical condition and prognosis in identifying relevant recreational and cultural activities.</li> <li>-As needed activities are tailored to meet the needs of residents with cognitive impairment or other special needs.</li> <li>-Once the interdisciplinary team has identified relevant activities for the resident, the resident is given an opportunity to choose when, where and how they will participate in activities and social events. If the resident prefers not to attend organized group programs, room visits will be provided based on the assessed interests of the resident.</li> </ul> <p>(continued on next page)</p>

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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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #22's Face Sheet showed the resident was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease (a progressive brain disorder, the most common cause of dementia, that gradually destroys memory and thinking skills, leading to difficulties with daily tasks and eventually, the inability to carry out even the simplest activities), failure to thrive, hemiplegia (paralysis) of the right dominant side, muscle wasting of the upper extremities, and cognitive communication deficit.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/9/25, showed the resident:</p> <ul style="list-style-type: none"> <li>-Had inattention, disorganized thoughts and significant memory loss.</li> <li>-Had no behavioral concerns.</li> <li>-Needed total assistance with bathing, dressing, toileting, transferring and eating and used a wheelchair for mobility.</li> <li>-The resident's activity preferences were not identified on this assessment.</li> </ul> <p>Review of the resident's Care Plan dated 12/18/24, showed the resident was dependent on staff for meeting emotional, intellectual, physical and social needs due to cognitive deficits and had little or no activity involvement related to disinterest and physical limitations. The goal was for the resident to express satisfaction with type of activities and level of activity involvement when asked through the review date. It showed the resident enjoyed church services, listening to music, playing bingo and was usually good at calling out the numbers, liked snacks and socializing. The resident said he/she also enjoyed watching football, participating in exercise groups, watching movies (comedies and westerns) and hobbies included shopping and his/her favorite colors are red, pink and white. Interventions showed:</p> <ul style="list-style-type: none"> <li>-The resident participated in activities weekly.</li> <li>-Invite/encourage the resident's family members to attend activities with resident in order to support participation.</li> <li>- Staff will provide Neen with activities she enjoys ie; Ice cream socials, monthly events, exercise groups, movies and television, music (Jazz and Blues).</li> <li>-Remind the resident that he/she may leave activities at any time, and was not required to stay for entire activity.</li> <li>-The resident needed one to one bedside/in-room visits and activities if unable to attend out of room events.</li> <li>-The resident needed a variety of activity types and locations to maintain interests.</li> <li>-The resident needed assistance/escort to activity functions.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary.</p> <p>-Introduce the resident to residents with similar background, interests and encourage/facilitate interaction.</p> <p>-Invite the resident to scheduled activities.</p> <p>-Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility.</p> <p>-Provide with activities calendar. Notify resident of any changes to the calendar of activities.</p> <p>-Review resident's activity needs with the family/representative.</p> <p>-Thank resident for attendance at activity function.</p> <p>Review of the resident's Special Programming One to One Log showed:</p> <p>-One to one activities for the resident occurred one time per week.</p> <p>-1/8/25-chair exercise arm movement; 1/15/25-played Connect 4 (game) dropping pieces in.; 1/22/25-no activity-resident sleeping; 1/29/25-listened to calming music.</p> <p>-2/5/25- had lunch and talked; 2/12/25-brushed hair and cleaned nails; 2/19/25-called out bingo numbers; 2/26/25-watched tv.</p> <p>-3/5/25-watched tv and talked about church; 3/12/25 went outside.</p> <p>Observation on 3/10/25 at 10:13 A.M., showed the resident was sitting in a high back wheelchair on the locked dementia unit with a daily chronicle (facility news paper) in front of him/her. The resident's hands was over his/her face and he/she was resting. There were no directed activities and no staff engagement in activities at this time. On the activity calendar on the wall showed 9:30 A.M. -daily chronicle; 10:00 A.M. IS (spirometer-a medical device used to measure the volume of air a person can breathe in and out) Program; 10:30 A.M. Waffle Social. From 10:13 A.M. to 12:21 P.M. showed there was no waffle social activity.</p> <p>Observation on 3/12/25 at 2:15 P.M., showed the resident was dressed and laying down in his/her bed. The television was on, the resident was awake but was resting. The activity calendar showed 2:30 P.M. Plant Making. The resident was not invited to any activity. There were no plant making activities that occurred at 2:30 P.M. on the unit. At 2:50 P.M. activity staff came onto the unit and provided popcorn to residents who accepted the snack. The resident had some popcorn and a drink.</p> <p>Observation on 3/13/25 at 11:10 A.M., showed the resident was sitting up in his/her high backed wheelchair dressed for the weather, and was sitting in front of the television in the sitting area. He/She was not watching the television. There was a group activity going on at this time that the resident was not invited to or brought over to passively participate in. The activity calendar showed there was no scheduled activity at this time.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/25 at 11:20 A.M., Hospice Nurse A said:</p> <ul style="list-style-type: none"> <li>-The resident was hard of hearing and had visual impairment and the staff took care of the resident, but he/she did not see them doing many activities with him/her.</li> <li>-The staff usually sat the resident in the television area, but the resident does not watch it.</li> <li>-He/She had spoken with the activity staff about having the resident sit with the group during activities.</li> <li>-He/She told the staff that the resident should be engaged and could participate in activities on the unit.</li> <li>-He/She had not seen anyone giving one to one activities to the resident, but earlier in the week they were playing Bingo and the resident was sitting in the tv area and he/she brought the resident to the table and the activity staff had the resident assist with calling out the numbers.</li> <li>-The resident liked jazz and would participate in activities.</li> </ul> <p>Observation on 3/13/25 at 2:45 P.M., showed the resident was laying down in his/her bed with his/her eyes closed resting comfortably. Activity staff came onto the unit and began gathering residents to play a bowling pong game. The resident remained resting in his/her room. The activity calendar showed Movie and Popcorn at 2:30 P.M.</p> <p>During an interview on 3/13/25 at 2:47 P.M., Certified Nursing Assistant (CNA) B said:</p> <ul style="list-style-type: none"> <li>-The resident does not really participate in activities due to his/her confusion.</li> <li>-They tried to bring the resident to activities daily.</li> <li>-The resident did not receive one to one activities and he/she had not seen activity staff do one to one activities with the resident.</li> <li>-This week the resident was able to assist with calling out the numbers during bingo. He/she repeated the number when the activity staff called it out.</li> </ul> <p>Observation 03/14/25 at 9:21 A.M., showed the resident was sitting up in his/her wheelchair in the tv area. The tv was on and there were three other residents sitting in front of the tv. The resident was not watching the tv, he/she was looking down at his/her hands and clothes. There was no activity at this time (the activity at 9:30 A.M. was Daily Chronicles). Nursing staff did not start an activity on or around 9:30 A.M.</p> <p>During an interview on 3/14/25 at 9:37 A.M., CNA C said:</p> <ul style="list-style-type: none"> <li>-They have activities on the unit daily, but most of the activities were group activities.</li> <li>-Some residents can participate in the activities and some cannot due to their cognitive status.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident does not participate in activities usually. They will give him/her snacks and he/she likes those but he/she slept a lot.</p> <p>-When the resident was up, he/she was usually in the tv area.</p> <p>-The resident does not have any one to one activities.</p> <p>-He/She had not seen the resident in any one to one activity provided by activity staff.</p> <p>-The activity staff follow the activity calendar and provide the activities listed on the calendar most of the time.</p> <p>-Nursing staff have papers and crayons that they have for the residents to color during the day or when the activity staff is not there to conduct activities.</p> <p>-There was usually the CNA and a nurse on the unit.</p> <p>-At 9:46 A.M., the CNA passed out snacks to residents that wanted or accepted one to include the resident.</p> <p>-There was no activity initiated.</p> <p>2. Review of Resident #90's Face Sheet showed the resident was admitted on [DATE], with diagnoses including dementia with agitation, lack of coordination, impulse disorder, and cognitive communication deficit.</p> <p>Review of the resident's annual MDS dated [DATE], showed the resident:</p> <p>-Had inattention, disorganized thoughts and significant memory loss.</p> <p>-Had no behavioral concerns.</p> <p>-Needed supervision with bathing, dressing, toileting, transferring and eating and ambulated independently without using an assistive device.</p> <p>-Activity preferences that were very important to the resident included, listening to music, animals, going outside, keeping up with the news and participating in groups.</p> <p>Review of the resident's Care Plan dated 1/20/25, showed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. It showed the resident enjoyed listening to and dancing to music, physical games where he/she is moving around, watching tv and movies, and going outside. The goal was for the resident to maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions showed staff would:</p> <p>-Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Ensure that the activities the resident is attending are compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), compatible with individual needs and abilities; and are age appropriate.</p> <p>-Introduce the resident to residents with similar background, interests and encourage/facilitate interaction.</p> <p>-Invite the resident to scheduled activities.</p> <p>-Provide with activities calendar. Notify resident of any changes to the calendar of activities.</p> <p>-Provide a program of activities that is of interest and empowers the resident by allowing choice, self-expression and responsibility.</p> <p>-Escort resident to activities, thank resident for attendance at activity function.</p> <p>Review of the resident's Special Programming One to One Log showed:</p> <p>-The resident was provided with one activity per week.</p> <p>-1/6/25 coloring page with number matching; 1/13/25 played duck in the pond game; 1/20/25 danced to music; 1/27/25 danced and listened to music</p> <p>-2/3/25 resident was sleeping; 2/10/25 played choice in music and dancing; 2/17/25 walked around the building; 2/24/25 painted nails and brushed hair.</p> <p>-3/3/25 large print reading-recognized several words; 3/10/25 walked around the building.</p> <p>Observation on 3/10/25 at 10:15 A.M., showed the resident was dressed and ambulating on the locked dementia unit. There were no directed activities and no staff engagement in activities at this time. On the activity calendar on the wall showed 9:30 A.M. -daily chronicle; 10:00 A.M. IS Program; 10:30 A.M. Waffle Social. From 10:15 to 12:21 P.M. showed there was no waffle social activity.</p> <p>Observation on 3/11/25 at 9:54 A.M., showed the resident was sitting in the dining area in front of the nursing station. The resident got up and began wandering on the unit and into resident rooms. Staff immediately re-directed the resident back to the dining area where the resident sat down in a chair. Staff did not provide the resident with an activity or anything to occupy him/her. On the activity calendar showed 9:30 A.M. Daily Chronicle; 10:30 A.M., IS Program. There was no activity occurring and no staff engagement with the residents.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 3/12/25 at 2:14 P.M., showed the resident was wandering on the unit up and down the hall. There were no activities occurring on the unit. At 2:28 P.M. staff provided residents with a choice of snack and beverage. The resident chose a snack and ambulated with his/her snack on the hall. At 2:50 PM activities staff came onto the unit and passed out popcorn to residents who wanted it and asked if they wanted to go play cards. The resident received popcorn and staff sat the resident down at the table and the resident ate his/her snack. After eating, he/she continued to wander on the unit. The activity calendar showed plant making activity At 2:30 P.M. and fresh air break at 3:30 P.M.</p> <p>Observation on 3/12/25 at 4:03 P.M. showed the resident participated in the fresh air activity (going outside).</p> <p>Observation on 3/13/25 at 11:02 A.M., showed the resident was ambulating on the unit. There was a group activity occurring on the unit that other residents were participating in. The resident would sit down for a while then would get up and begin ambulating around the unit again. The resident ambulated into another resident's room and staff immediately went to get the resident and walked with him/her on the unit, but did not bring him/her to the activity. Staff provided the resident a drink and the resident sat down and drank. Once he/she was finished, he/she began to wander on the unit.</p> <p>Observation on 3/13/25 at 2:41 P.M., showed the resident was wandering up and down the hall on the unit. The activity staff came onto the unit and asked residents who wanted to play a game yard pong. Nursing staff gave the resident a snack that he/she ate while standing at the nursing station. The resident did not participate in the activity and continued to wander on the unit after eating his/her snack.</p> <p>During an interview on 3/13/25 at 2:47 P.M., CNA B said:</p> <ul style="list-style-type: none"> <li>-The resident will only sit for a few minutes at a time and it was difficult to get him/her to participate in organized activities because he/she always walks.</li> <li>-They primarily will give the resident snacks and they will walk with him/her on the unit.</li> <li>-The resident was not on one to one activities and he/she had not seen the activity staff conduct one to one activities with the resident.</li> <li>-They really don't have any one to one activities on the unit.</li> <li>-The activity staff provide activities on the unit daily, but the resident rarely participates.</li> </ul> <p>- At 3:05 P.M., the activity staff stopped the resident and handed him/her a ball to toss into the bucket. The resident did so and then continued to wander on the hall while other residents took turns playing the game.</p> <p>Observation on 3/13/25 at 3:30 P.M., showed activity staff was walking with resident outside on the front patio with other residents (this was a planned activity).</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 3/14/25 at 9:20 A.M., showed the resident was wandering on the unit, ambulating up and down the hall. The activity Daily Chronicle was supposed to start at 9:30 AM. There was no activity staff on the unit and nursing staff was assisting residents with toileting and personal care.</p> <p>During an interview on 3/14/25 at 9:37 A.M., showed CNA C said:</p> <ul style="list-style-type: none"> <li>-They do have activities on the unit daily, but most of the activities are group activities.</li> <li>-Some residents can participate and some cannot due to their cognitive status.</li> <li>-The resident wandered all day long and sometimes would sit down during an activity but only for a very short period of time.</li> <li>-The resident does not receive one to one activities and he/she had not seen activity staff conduct one to one activities with the resident.</li> <li>-The resident participated in snacks, but would still wander on the unit.</li> <li>-They had to watch the resident to keep him/her from going into other resident rooms.</li> </ul> <p>-At 9:47 A.M., CNA C passed out snacks and was able to get the resident to sit down long enough to eat it, but then the resident got up when he/she was finished and continued to wander the hall.</p> <p>3. During an interview on 3/14/25 at 10:17 A.M., the Activity Director said:</p> <ul style="list-style-type: none"> <li>-They have 3 activity staff-the Activity Director and two activity assistants.</li> <li>-He/She completes activities on the locked dementia unit and the assistants are on the other units.</li> <li>-They usually have three activity staff during the week and two on weekends.</li> <li>-The IS Program is a spirometer breathing program they initiated to try to encourage resident participation with breathing exercises.</li> <li>-They also have hydration station which is to encourage residents to drink water or some beverage.</li> <li>-They incorporate snacks which gets more participation with the activities.</li> <li>-On the locked unit he/she will do similar activities like bingo, [NAME] the table (dice rolling game) that are simple activities that the residents can participate in. He/She will modify the activity for the dementia residents.</li> <li>-He/She will also take residents outside to enjoy the weather and sometimes he/she will incorporate an activity while outside.</li> <li>- They do not have very much documentation of resident participation in activities on the locked unit.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident #90 should have an individualized activity plan that should be time sensitive due to his/her ambulation and wandering, limited attention span. The resident may only participate in activities in short periods or in certain activities. He/She would expect the activities to be on the care plan and should be goal oriented specifically for this resident's ability to participate.</p> <p>-He/She expected all activity participation for each resident to be documented.</p>

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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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on observation, interview and record review, the facility failed to ensure one sampled resident(Resident #104) did not keep smoking materials including cigarettes and a lighter in his/her room, and failed to ensure the resident was only smoking in the smoke area not in his/her room; and failed to ensure to protective oversight and supervision to maintain a safe environment during smoking breaks, and to failed ensure resident assigned smoking area was free of potential hazards including wood, nails and broken equipment for one sampled resident (Resident #103) out of 29 sampled residents. The facility census was 140 residents.</p> <p>Review of the facility's policy, Smoking by Residents, dated November 2023 showed:</p> <ul style="list-style-type: none"> <li>-Smoking was not allowed anywhere inside the facility.</li> <li>-The facility permits smoking only in the areas designated by the facility's Safety Committee.</li> <li>-The facility discourages smoking by residents and ensures that those resident who choose to smoke did so safely.</li> <li>-Residents who wanted to smoke would have been assessed for their ability to smoke safely prior to being allowed to smoke independently in those areas.</li> <li>-Residents who were not able to smoke independently and safely would have been accompanied by facility staff while smoking.</li> <li>-The facility would have created a Smoking Care Plan for the resident.</li> <li>-All smoking materials would have been stored in a secure area to ensure they were kept safe.</li> <li>-Example of a secure areas included; a labeled box in a locked medication room and clearly identified with the resident's name and room number.</li> <li>-Residents were prohibited from soliciting smoking materials from staff and visitors.</li> <li>-Response to resident non-compliance with smoking rules included: <ul style="list-style-type: none"> <li>-First offense was a written letter issued to the resident and /or family regarding non-compliance.</li> <li>-Second offense was a written letter issued to the resident and/or family referencing the first offense letter and advising that a third offense results in the loss of smoking privileges.</li> <li>-Third offense was a letter issued to the resident and/or family outlining the non-compliant behavior. At this time the resident lost their smoking privileges.</li> </ul> </li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #104's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Lack of coordination.</li> <li>-Need for assistance with personal cares.</li> </ul> <p>-Hemiplegia (weakness on one side of the body) and Hemiparesis (muscle weakness on one side of the body) following Cerebral Infarction (Stroke - a condition where blood flow to the brain was interrupted causing brain cells to die) affecting right dominant side.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/20/25 showed:</p> <ul style="list-style-type: none"> <li>-The resident was moderately cognitively impaired.</li> <li>-He/She put other residents at risk was not checked.</li> <li>-He/She put self at risk was not checked.</li> <li>-He/She had a stroke.</li> <li>-He/She had hemiplegia.</li> </ul> <p>Review of the resident's care plan dated 2/25/25 showed:</p> <ul style="list-style-type: none"> <li>-He/She was a smoker.</li> <li>-He/She would not smoke without supervision.</li> <li>-He/She would follow all facility smoking rules.</li> <li>-Staff would educate family members to go to the nurse when smoking items were brought into the the facility.</li> <li>-They (smoking materials) have to have been given to nursing to follow smoking policy and facility rules.</li> <li>-Staff was to notify Assistant Director of Nursing (ADON), Director of Nursing (DON), Social Services (SS), Physician, Nurse Practitioner (NP), and Administrator if rules were broken for smoking.</li> <li>-A copy of the smoker's contract was signed and in the resident's medical record.</li> <li>-Cigarettes or other smoking materials and lighter were required to have been stored at the nurses' station.</li> <li>-Staff was to instruct the resident about the facility policy on smoking; location, times, safety concerns.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Safe Smoking Evaluation dated 3/12/25 showed:</p> <ul style="list-style-type: none"> <li>-He/She was a smoker.</li> <li>-He/She knew the location of the designated areas for smoking.</li> <li>-He/She was able to get to those areas independently.</li> <li>-He/She was able to independently light smoking materials safely when observed.</li> <li>-He/She was able to extinguish smoking materials completely in an appropriate receptacle.</li> <li>-He/She was able to dispose of ashes or other tobacco related residue appropriately.</li> <li>-He/She was safe to smoke with minimal supervision.</li> </ul> <p>Observation on 3/13/25 at 1:05 P.M. showed:</p> <ul style="list-style-type: none"> <li>-There was a smell of smoke in the hallway outside of the resident's room.</li> <li>-The resident came out of the restroom and smoke flowed out of the resident's restroom.</li> <li>-The resident went over to his/her side of the room and opened the window.</li> <li>-The resident was alone in the room.</li> <li>-The Wound Care Nurse was down the hallway and was notified of the smell of smoke.</li> <li>-The Nurse smelled smoke from the resident's room.</li> <li>-The Nurse entered the resident's room.</li> <li>-Cigarette ashes were observed on the toilet seat in the resident's restroom.</li> <li>-The Nurse asked the resident if he/she had been smoking in the room.</li> <li>-The resident said no.</li> <li>-The Nurse asked if the resident's roommate had been smoking in the room and he/she said no.</li> <li>-The Nurse asked the resident if he/she had any cigarettes or a lighter in the room.</li> <li>-The resident gave the Nurse a pack of opened cigarettes, a pack of cigars, and a lighter.</li> <li>-The resident said he/she knew that he/she was not supposed to have smoking materials in the room, the smoking materials were to have been kept by the staff and locked in the smoking cart.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Residents were to have kept smoking materials in the cigarette cart not in their rooms.</p> <p>-Residents were not to have smoked in their rooms.</p> <p>-If a resident was found smoking in their rooms staff should have confiscated the smoking materials.</p> <p>-Staff should have told the DON if a resident had smoking materials in their room or had been found smoking in their room.</p> <p>-The resident should then have been educated about the smoking policy.</p> <p>-Smoking assessments should have been done quarterly.</p> <p>-The resident was able to smoke without supervision.</p> <p>-He/She did not know anything about the residents getting letters regarding their smoking.</p> <p>-He/She did not see that the resident had received a letter regarding smoking in his/her chart.</p> <p>-The resident had been caught smoking previously and had received education but nothing else.</p> <p>-There were other residents on that hallway where the resident resided that were on oxygen and it would have been dangerous if they were smoking in their rooms.</p> <p>During an interview on 3/14/25 at 2:25 P.M. the DON said:</p> <p>-If a resident was found smoking anywhere but the designated smoking area he/she expected staff to have told him/her and confiscate the smoking material and then tell him/her.</p> <p>-Smoking material should be locked in the smoking cart then handed out to the residents' at smoking time.</p> <p>-After smoking time the residents should have given the smoking material back to the staff to lock in the smoking cart.</p> <p>-Residents should not have had smoking materials in their rooms.</p> <p>-Social Services would educate the resident and family about their smoking policy.</p> <p>-The resident was able to smoke without supervision.</p> <p>-At this time they educated the resident about smoking he/she did not know anything about a letter.</p> <p>-There were residents on the same hallway who were on oxygen and that was why they were only supposed to have smoked in the designated area.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>33409</p> <p>2. Review of Resident #103's face-sheet showed he/she was admitted with diagnosis to include: stroke, Psychosis (a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not), vascular Dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), Major Depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily).</p> <p>Review of the resident's quarterly MDS dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-The resident was cognitively intact able to make his/her needs known.</li> <li>-The resident did not have documentation during the look back period related to smoking.</li> </ul> <p>Review of the resident's POS dated 2/11/25 showed the resident:</p> <ul style="list-style-type: none"> <li>-The resident resides on secure unit due to diagnosis of Dementia.</li> <li>-May attend activities in dining area and other parts of the facility.</li> </ul> <p>Review of the resident's Alert charting dated 3/7/25 at 4:31 P.M., written by ADON A showed:</p> <ul style="list-style-type: none"> <li>-While the resident was outside on smoking break, staff noted the resident holding a 2 x 4 board with nails sticking out one end.</li> <li>-The resident attempted to bring the board into the building and staff informed him/her that could not bring board into the building.</li> <li>-The resident attempted to push pass then and staff ran into building closed the door.</li> <li>-The resident proceeded to punch the door glass window and cracked it.</li> <li>-Facility staff attempted to calm the resident and gave the resident another cigarette.</li> <li>-While the resident was smoking, the nurse was able to encourage the resident to give the nurse the board.</li> <li>-Facility staff called 911.</li> <li>-Police had arrived and spoke with the resident and the resident proceeded to shove the police officer.</li> <li>-The resident was sat down by the police while they attempted to speak to the resident.</li> <li>-Facility staff noted three large rocks and broken call light cord on the resident walker.</li> <li>-Police officer asked the resident if they could check his/her pockets and resident agreed.</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she felt the facility staff were not always watching the resident during smoke breaks.</p> <p>-He/she had seen the resident walk down the sidewalk toward dumpster area and back without staff monitoring the resident.</p> <p>During interview on 3/11/25 at 10:50 A.M., Director of Nursing (DON) said the resident during a smoke break obtained a board with nails and rocks.</p> <p>During an interview on 3/13/25 11:27 A.M., CNA G said:</p> <p>-The hospitality aid had brought the resident outside from the locked unit.</p> <p>-He/she was outside in smoke area while on his/her break.</p> <p>-He/she went inside and closed the door quickly before the resident could enter the building with the board.</p> <p>-The resident then punched the window with his/her fist and shattered the door glass.</p> <p>-He/she had called the DON and then police arrived took over the incident.</p> <p>-Resident was verbally and physically aggressive and police had taken broken call light cord, rocks and other items that the resident had on himself/herself and on the walker.</p> <p>-At the time of the incident there were other facility staff in the smoking area along with other resident.</p> <p>-He/she had not seen the resident go get the board with the nails.</p> <p>-He/she had received training on how calm a resident or to de-escalate the situation.</p> <p>During an interview on 3/13/25 at 11:48 A.M., Licensed Practical Nurse (LPN) B said:</p> <p>-He/she was notified of incident smoke area and that needed licensed nursing staff immediately to smoke area.</p> <p>-He/she went out and calmly ask the resident for the 2 x 4 board.</p> <p>-He/she obtain a cigarette to calm the resident down.</p> <p>-Police arrive and escorted the resident form smoking area and out of the front door of the building.</p> <p>-Hospitality staff were responsible for supervise the resident while on smoke breaks.</p> <p>During an interview on 3/13/25 at 3:38 P.M., Administrator said:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Due to recent behavioral during smoke breaks and collection of potential weapons such as rocks and other broken, the resident was not safe to be at the facility for his/her safety and for the safety other resident at the facility.</p> <p>During an interview on 3/14/25 at 11:59 A.M., Medical Record staff A said:</p> <ul style="list-style-type: none"> <li>-The facility uses smoking breaks to assist in calming the resident.</li> <li>-The resident required monitoring while outside.</li> <li>-He/she had not seen the resident wander away from the smoke section when he/she was outside.</li> <li>-Medical record staff would also assist in monitoring the residents on locked unit.</li> </ul> <p>During an interview on 3/14/25 at 12:05 P.M., CNA H said:</p> <ul style="list-style-type: none"> <li>-The facility's hospitality staff were responsible for taking the the resident out to smoke and monitor the resident while in the smoking area.</li> <li>-He/she had completed the facility dementia care training on handling resident with behaviors.</li> </ul> <p>During an interview on 3/14/25 at 12:19 P.M., Assistant Director of Nursing (ADON) B said:</p> <ul style="list-style-type: none"> <li>-The resident from the locked unit should be monitored at all the times on and off the unit.</li> <li>- He/she was not aware of the resident wandering away or walking down sidewalk during smoking breaks.</li> <li>-The facility was not aware how the resident obtained rocks and board with nails and had been brought into the facility.</li> <li>-Since the election in November the resident mental status changed and increase delusion and paranoid.</li> </ul> <p>During an interview on 3/14/25 at 2:30 P.M., DON said:</p> <ul style="list-style-type: none"> <li>-The facility hospitality aid would be responsible for monitoring of the resident during smoking breaks and would be provided the same training as Certified Nursing Assistant (CNA) on how to monitoring/redirection of the resident during smoking times and to notify their supervisor of incident occur while monitoring the resident.</li> <li>-The DON was not aware the resident had wandered down the sidewalk to the dumpster area or over to the maintenance garage area during a smoking break.</li> <li>-Maintenance staff would be responsible for cleanness of the area around the garage.</li> <li>-All facility staff would be responsible to ensure safety of the resident while outside smoking and known whereabouts all resident outside during smoking breaks.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Resident from locked unit were required to have supervised smoke breaks and should ensure those residents do not wander outside the assigned smoking area.</p> <p>COMPLAINT# MO 00250871</p>

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  03/14/2025
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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21003</p> <p>Based on observation, interview and record review, the facility failed to serve the physician ordered texture and portion size to one sampled resident (Resident #22) with swallowing difficulties and who was at risk for weight loss out of 29 sampled residents. The facility census was 140 residents.</p> <p>Review of the facility's Therapeutic Diet policy and procedure dated 12/2020, showed:</p> <ul style="list-style-type: none"> <li>-The purpose was to ensure that the facility provided therapeutic diets to residents that meet nutritional guidelines and physician orders.</li> <li>-Therapeutic diets would not be given without a physician's order.</li> <li>-The therapeutic diet would be reflected on the resident's diet tray card.</li> <li>-The Nutrition Services Manager was responsible for ensuring each food item was pureed and served separately for a pureed diet per the menu and recipe and food portions are equal to the written portion sizes.</li> <li>-The Nutrition Services Manager would periodically review the resident's tray card and the physician's nutrition orders to ensure the information is consistent.</li> </ul> <p>1. Review of Resident #22's Face Sheet showed the resident was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease (a progressive brain disorder, the most common cause of dementia, that gradually destroys memory and thinking skills, leading to difficulties with daily tasks and eventually, the inability to carry out even the simplest activities), failure to thrive, hemiplegia (paralysis) of the right dominant side, muscle wasting of the upper extremities, and cognitive communication deficit.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/9/25, showed the resident:</p> <ul style="list-style-type: none"> <li>-Had inattention, disorganized thoughts and significant memory loss.</li> <li>-Needed total assistance with bathing, dressing, toileting, transferring and eating and used a wheelchair for mobility.</li> <li>-Received a mechanically altered therapeutic diet.</li> <li>-There was no documentation showing the resident had a chewing or swallowing concern.</li> </ul> <p>Review of the resident's Care Plan dated 12/18/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident had nutritional problem or potential nutritional problem. Interventions showed:</li> <li>-Invite the resident to activities that promote additional intake.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident would eat all meals in the main dining room at assisted tables, staff to assist as needed.</p> <p>-Obtain and monitor lab/diagnostic work as ordered. Report results to the physician and follow up as indicated.</p> <p>-Provide and serve supplements as ordered: House supplement, house shake.</p> <p>-Provide, serve diet as ordered. Monitor intake and record every meal.</p> <p>-Registered Dietician to evaluate and make diet change recommendations as needed.</p> <p>-Weigh per facility protocol/physician order and as needed. Make every effort to do same time of day and use same method.</p> <p>Review of the resident's Physician's Order Sheet (POS) dated 3/2025, showed physician's orders for:</p> <p>- Regular diet, puree (food texture is finely ground like that of baby food or mashed potatoes) texture, thin consistency, comfort whole foods when requested by hospice (1/3/25).</p> <p>-House 2.0 Supplement one time a day 100 milliliters (ml) consistency (1/3/25).</p> <p>-Resident is at risk for malnutrition related to new admission and diagnosis; will weigh monthly thereafter. Dietician to consult as needed, per orders (12/11/24).</p> <p>-Use of a plate guard at meal time to promote independence with eating (12/2/24).</p> <p>Observation and record review on 3/10/25 at 12:06 P.M., showed the resident was in his/her high backed wheelchair sitting at the dining room table. The resident was served a pureed diet with potatoes, green vegetable, and brown pureed meat and vanilla pudding. Review of the resident's diet card showed a regular pureed diet with large portions. The portions on the resident's plate were a regular, not large portion size.</p> <p>Observation on 3/14/25 at 11:34 A.M., showed the resident was sitting in the TV area. At 11:54 A.M., nursing staff brought the resident to the dining table to feed the resident. The resident received a pureed diet of meat, mashed potatoes with gravy and peas. The resident was served a regular fruit cup of oranges. The resident did not receive large portions. Certified Nursing Assistant (CNA) E began feeding the resident. Review of the diet card showed resident was to receive pureed diet with large portions.</p> <p>Observation and interview on 3/14/25 at 12:00 P.M., showed CNA E said:</p> <p>-The resident was served a regular dessert and it was supposed to be pureed and he/she was supposed to be served large portions and was not.</p> <p>-He/She was going to page dietary to have them bring the correct dessert. At 12:00 PM he/she paged dietary. He/She informed the Dietary Manager that they had not provided the resident with a pureed dessert and had not provided large portions for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The dietary staff rarely served the resident large portions.</p> <p>-They really need to begin to look at the diet cards.</p> <p>During an interview on 3/14/25 at 12:21 P.M., showed CNA C said:</p> <p>-The resident normally received regular portions and rarely received large portions.</p> <p>-The resident was supposed to receive a pureed diet with large portions according to his/her diet card.</p> <p>-They feed the resident and the resident would usually eat most if not all of his/her meal.</p> <p>During an interview on 3/14/25 at 12:34 P.M., the Dietary Manager said:</p> <p>-When they are preparing the resident plates in the kitchen, the cook is supposed to prepare it by what is on the resident's diet card.</p> <p>-They made a mistake and did not give the pureed dessert.</p> <p>-The resident was supposed to receive large portions and they corrected this also today.</p> <p>-Nursing staff was also supposed to check the resident's diet card to ensure he/she received the correct diet and if the diet was wrong, they should notify the dietary staff.</p> <p>-Nursing staff had not informed them that the resident had not been receiving large portions.</p> <p>-He/She will ensure the resident's diet order is correct.</p> <p>During an interview on 3/14/25 at 2:26 P.M., the Director of Nursing (DON) said:</p> <p>-He/She expected the resident's physician ordered diet order to be followed.</p> <p>-The diet card should show the resident's ordered diet including dietary initiatives of the Registered Dietician.</p> <p>-If the resident's diet card showed double or large portions, he/she expected that to be followed.</p> <p>-The nursing staff was supposed to document the resident's meal consumption so they would be able to see if the resident was eating large portions.</p> <p>-Large portions usually was a Dietitian intervention so they should continue the intervention and let the Dietitian know what the resident is eating so he/she could decide whether to continue the intervention or not.</p> <p>-He/She expected nursing staff would document concerns about the resident's diet order to be documented in the resident's medical record.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She was made aware of the resident not receiving the correct diet and the dietary staff would correct it.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on observation, interview, and record review, the facility failed to provide a nebulizer (a machine that turns liquid medicine into a mist that could have been easily inhaled) was available for respiratory treatments for one sampled resident, (Resident #10); failed to ensure the Continuous Positive Airway Pressure (CPAP a machine that delivers enough air pressure to a mask to keep the upper airway passages open during sleep) mask was correctly placed for one sampled resident, (Resident # 126) and failed to ensure oxygen equipment was stored in a sanitary manner for two sampled residents, (Resident #68 and Resident #126) out of 29 sampled residents. The facility census was 140 residents.</p> <p>Review of the facility's policy, Oxygen Administration, dated 6/2020 showed:</p> <ul style="list-style-type: none"> <li>-A physician's order was required to initiate oxygen therapy.</li> <li>-All oxygen tubing, humidifiers (a container for distilled water), masks, and cannulas (oxygen tubing) used to deliver oxygen would have been changed weekly and when visibly soiled.</li> <li>-Oxygen items would have been stored in a plastic bag to protect the equipment from dust and dirt when not in use.</li> <li>-Oxygen was to have been stored in a clean dry place.</li> <li>-For a face mask staff was to have placed the mask on face, applying it from the nose and over the chin.</li> <li>-Adjust the metal rim over the nose and contour the mask to the face.</li> </ul> <p>1. Review of Resident #10's face sheet showed he/she was readmitted on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/21/25 showed:</p> <ul style="list-style-type: none"> <li>-He/She was cognitively intact.</li> <li>-He/She had resistor failure.</li> <li>-He/She had COPD.</li> <li>-Did not show any respiratory treatments.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's March 2025 Physician's Order Sheet (POS) showed the following order Ipratropium-Albuterol Inhalation Solution (a combination of medications used to open your airways and reduce inflammation in your lungs to breathe easier) 0.5 - 2.5 (3) milligram (mg)/3 milliliter (ml) inhale orally every four hours as needed for shortness of air, dated 3/6/25.</p> <p>Review of the resident's care plan dated 3/6/25 showed:</p> <ul style="list-style-type: none"> <li>-He/She had COPD.</li> <li>-Staff was to give aerosol as ordered, dated 12/4/24.</li> </ul> <p>During an interview on 3/11/25 at 11:02 A.M. the resident said:</p> <ul style="list-style-type: none"> <li>-He/She had a bad night a couple of nights ago and it was hard to breathe.</li> <li>-He/She had asked for a nebulizer treatment.</li> <li>-The nurse had given him/her a inhaler treatment (breathing treatment) instead as there was no nebulizer in his/her room.</li> <li>-Two months ago he/she had moved from the 400 hall into his/her current room.</li> <li>-When the staff moved him/her they had brought the nebulizer machine and put it in his/her nightstand drawer.</li> <li>-Staff had not brought the mouthpiece with the machine so he/she was not able to use it.</li> <li>-He/She slept better at night after a nebulizer treatment.</li> <li>-He/She has asked several times for the staff to go back to his/her old room and look for the rest of the nebulizer, which they have not done.</li> </ul> <p>Observation on 3/11/25 at 11:05 A.M. showed:</p> <ul style="list-style-type: none"> <li>-The resident had a nebulizer machine in his/her nightstand.</li> <li>-The nebulizer was missing the tubing and mouthpiece.</li> </ul> <p>During an interview on 3/12/25 at 3:20 P.M. the resident said:</p> <ul style="list-style-type: none"> <li>-He/She had asked the staff again to look for the missing pieces of the nebulizer or could they get him/her a new one.</li> <li>-Staff did not provide the missing pieces nor did they obtain a new nebulizer.</li> </ul> <p>Observation on 3/12/25 at 3:25 P.M. showed the nebulizer was still in his/her nightstand without the missing pieces.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/25 at 11:00 A.M. Assistant Director of Nursing (ADON) A said:</p> <ul style="list-style-type: none"> <li>-There was a mouth piece to the nebulizer and it was in a bag in the resident's room.</li> <li>-He/She changed the mouthpiece out every week.</li> <li>-He/She gave the resident a breathing treatment with the nebulizer yesterday.</li> </ul> <p>Observation on 03/13/25 at 11:03 A.M. showed:</p> <ul style="list-style-type: none"> <li>-The nebulizer was still in the drawer of the nightstand.</li> <li>-There was no mouth piece anywhere in the room.</li> </ul> <p>During an interview on 3/13/25 at 11:05 A.M. the resident's roommate said:</p> <ul style="list-style-type: none"> <li>-The resident had woke him/her up trying to catch his/her breath the other night.</li> <li>-Nursing gave the resident a hand held puffer (inhaler) treatment.</li> <li>-They never brought the mouthpiece for the nebulizer after he/she had moved from the other hall.</li> <li>-The resident had asked staff a couple of times to look for the rest of his/her breathing machine in the old room.</li> </ul> <p>During an interview on 3/14/25 at 10:00 A.M. the resident said he/she did not have the tubing or mouth piece for his/her nebulizer until last night when staff finally brought a new one.</p> <p>2. Review of Resident #126's face sheet showed he/she was admitted to the facility on [DATE] with a diagnosis of Obstructive Sleep Apnea (intermittent airflow blockage during sleep).</p> <p>Review of the resident's annual MDS assessment dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-He she was cognitively intact.</li> <li>-Pulmonary (breathing) issues was not checked.</li> <li>-CPAP was not checked.</li> </ul> <p>Review of the resident's care plan dated 2/19/25 showed:</p> <ul style="list-style-type: none"> <li>-He/She had altered respiratory status/ difficulty breathing related to Sleep Apnea dated 11/19/24.</li> <li>-He/She was to use the CPAP at bedtime and as needed when sleeping.</li> <li>-Staff was to monitor placement of mask, dated 2/10/25.</li> </ul> <p>Review of the resident's March 2025 POS showed the following orders:</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitor placement of mask as needed for Sleep Apnea, dated 1/5/25.</p> <p>-Monitor placement of mask at bedtime for Sleep Apnea, dated 1/5/25.</p> <p>During an interview on 3/11/25 at 11:10 A.M. the resident said:</p> <p>-They have never cleaned the CPAP mask or nebulizer mouthpiece.</p> <p>-The jug of water on the floor was for CPAP.</p> <p>-He/She had a hard time keeping the CPAP mask on when he/she slept because of his/her facial hair.</p> <p>Observation on 03/11/25 11:14 AM showed he/she had a CPAP machine sitting on his/her nightstand.</p> <p>Observation on 3/11/25 at 1:40 P.M. showed:</p> <p>-The resident was asleep wearing the CPAP mask.</p> <p>-The CPAP mask was askew, not sitting straight on his/her face the oxygen was leaking out of the sides of the mask.</p> <p>Observation on 3/11/25 at 3:00 P.M. showed:</p> <p>-The resident was asleep wearing CPAP mask.</p> <p>-The resident's mask was askew, with oxygen leaking out the sides of the mask.</p> <p>Observation on 3/14/25 at 1:20 P.M. showed:</p> <p>-The resident was asleep in bed wearing the CPAP mask.</p> <p>-The mask was askew with oxygen leaking out of the sides.</p> <p>During an interview on 3/14/25 at 10:30 A.M. Certified Nursing Assistant (CNA) A said:</p> <p>-The Nurses take care of the oxygen equipment.</p> <p>-It was hard to keep the CPAP on Resident #126, he/she had a beard and it slips off sometimes when he/she sleeps.</p> <p>-If you wake him/her up to put the mask on he/she gets mad.</p> <p>-He/She had not seen the parts for Resident #10 nebulizer, if they moved from a different hall all their belongings should have come with them.</p> <p>-He/She had not been asked to look in the resident's old room for the nebulizer parts.</p> <p>During an interview on 3/14/25 at 11:00 A.M. Registered Nurse (RN) A said:</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She would have expected a nebulizer to have all the pieces and been available for the resident to use as soon as there was a physician's order.</p> <p>-They have all the pieces for a nebulizer and would take less than five minutes to ensure all of the pieces were there or to get a new nebulizer with all the pieces.</p> <p>-The Nurses were in charge of the oxygen equipment.</p> <p>-The ADON goes around each week and checks on the oxygen equipment.</p> <p>During an interview on 3/14/25 at 2:25 P.M. the Director of Nursing (DON) said:</p> <p>-The Nursing staff was responsible for the oxygen equipment.</p> <p>-The ADON makes rounds on Mondays to audit the oxygen equipment.</p> <p>-There should have been all the components with the nebulizer or staff should have obtained a new one.</p> <p>-Staff were expected to follow the physician's orders.</p> <p>-If a resident did not have a CPAP mask on correctly it would not have been effective.</p> <p>3. Review of Resident #68's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Respiratory failure (when the lungs can not properly exchange gases).</p> <p>-Malignant neoplasm of Larynx (cancerous cell in the voice box which helps you breathe and make noises).</p> <p>-Malignant neoplasm of left lung (cancerous cells in the lung).</p> <p>-Tracheostomy status (a surgical procedure to create an opening in the neck and into the windpipe to help a person breathe).</p> <p>Review of the resident's quarterly MDS dated [DATE] showed:</p> <p>-He/She was cognitively intact.</p> <p>-He/She had respiratory failure.</p> <p>-Staff were to complete tracheostomy cares.</p> <p>-Oxygen therapy was not checked.</p> <p>Review of the resident's care plan dated 1/31/25 showed:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had altered respiratory status/difficulty breathing.</p> <p>-Staff was to maintain a clear airway by encouraging resident to cough. If secretions could not be cleared, suction as ordered.</p> <p>-His/Her oxygen setting was oxygen via mask (a mask that provides a method to transfer breathing oxygen gas from a storage tank to the lungs) at two liters per minute.</p> <p>Review of the March 2025 Physicians' Order Sheet (POS) showed the following orders:</p> <p>-May suction every hour as needed for tracheostomy cares.</p> <p>-Oxygen at two liters per minute per trachea shield (a form of oxygen mask that delivers oxygen to a tracheostomy or stoma - the hole that remains after tracheostomy tube was removed) as needed for shortness of air.</p> <p>Observation on 3/10/25 at 10:35 A.M. showed:</p> <p>-The resident had a stoma with a trachea shield over it with oxygen turned on.</p> <p>-The oxygen was delivered by a concentrator (a medical device that delivers 95% pure oxygen) which had a humidifier reservoir (distilled water - purified water, which combines with the oxygen to decrease dryness when using oxygen).</p> <p>-There was no date on the oxygen tubing or trachea shield which showed when it had been changed.</p> <p>-The distilled water jug was sitting on the floor, there was no date which showed when the water jug had been opened.</p> <p>-The suction machine was sitting on the floor not in a bag.</p> <p>-The tubing to the suction machine was in a bag without a date on it.</p> <p>Observation on 3/11/25 at 10:40 AM showed:</p> <p>-The resident had a stoma with a trachea mask delivering oxygen.</p> <p>-There was no date which showed when it was changed.</p> <p>-The oxygen concentrator had a humidifier for distilled water.</p> <p>-The water jug was sitting on the floor, there was no date the jug of distilled water had been opened.</p> <p>-There was a suction machine sitting on the floor.</p> <p>-The suction machine was sitting on the floor not in a bag.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The tubing to the suction machine was in a bag without a date on it.</p> <p>Observation on 3/13/25 at 11:48 A.M. showed:</p> <p>-The resident was out of the room.</p> <p>-The oxygen mask and tubing was wrapped around the oxygen concentrator.</p> <p>-There was no bag for the oxygen tubing or mask.</p> <p>-The was a jug of water for the humidifier sitting on the floor with no opened date written on it.</p> <p>-The suction machine was sitting on floor, not in a bag.</p> <p>-The tubing that was attached to the suction machine was in a bag with no date on it.</p> <p>Observation on 3/13/25 at 1:35 P.M. showed:</p> <p>-The resident was lying in bed.</p> <p>-The resident had a stoma with a trachea mask delivering oxygen.</p> <p>-There was no date which showed when it was changed.</p> <p>-The oxygen concentrator had a humidifier for distilled water.</p> <p>-The water jug was sitting on the floor, there was no date the jug of distilled water had been opened.</p> <p>-There was a suction machine sitting on the floor.</p> <p>-The suction machine was sitting on the floor not in a bag.</p> <p>-The tubing to the suction machine was in a bag without a date on it.</p> <p>During an interview on 3/13/25 at 1:40 P.M. the resident:</p> <p>-Declined to talk as it was too hard for him/her.</p> <p>-He/She nodded his/her head yes that was the normal oxygen set up for him/her.</p> <p>-He/She shrugged his/her shoulders when asked if staff changes the oxygen equipment.</p>

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Hilltop at Blue River, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on interview and record review, the facility failed to have sufficient staff on the weekends to provide care and services for residents and for one sampled resident (Resident #10) out of 29 sampled residents. The facility census was 140 residents.</p> <p>Review of the facility's policy, Staffing, Scheduling, and Posting, dated 06/2020 showed:</p> <ul style="list-style-type: none"> <li>-Staffing an adequate number of nursing service personnel, scheduling would have been done as needed to meet the residents' needs and would have accounted for the number, acuity and diagnoses of the facility resident populations.</li> <li>-The facility would have submitted to the Centers for Medicare and Medicaid Services (CMS - a federal agency that administers programs along with other health related initiatives) complete and accurate direct care staffing information based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.</li> <li>-The Director of Nursing (DON) or designee was responsible for validating the accuracy of data on such staffing and census forms.</li> </ul> <p>1A. Review of the CMS Payroll Based Journal (PBJ) for the period of January 1, 2024 through March 31, 2024 showed the report was triggered for excessively low weekend staffing.</p> <p>1B. Review of the Daily Staffing Sheets for January 2024 showed the following shortages for weekend staffing:</p> <ul style="list-style-type: none"> <li>-1/6/24 - Day shift short two Certified Nursing Assistants (CNA)s.</li> <li>-Evening shift short four CNAs.</li> <li>-1/7/24 -Evening shift short three CNAs.</li> <li>-Night shift short one CNA.</li> <li>-1/13/24 - Evening shift short three CNAs.</li> <li>-1/20/24 -No documentation.</li> <li>-1/21/24 -No documentation.</li> <li>-1/27/24 -Evening shift short three CNAs.</li> <li>-Night shift short one CNA.</li> <li>-1/28/24 -Day shift short two CNAs.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Evening shift short one CNA.</p> <p>-Night shift short one CNA.</p> <p>1C. Review of the Daily Staffing Sheets for February 2024 showed the following shortages for weekend staffing:</p> <p>-2/3/24 - Day shift short two CNAs.</p> <p>-Evening shift after 8:00 P.M. short eight CNAs.</p> <p>-Night shift short one CNA.</p> <p>-2/4/24 -Evening shift after 8:00 P.M. short three CNAs.</p> <p>-Night shift short one CNA.</p> <p>-2/10/24 Day shift short two CNAs.</p> <p>-Evening shift short four CNAs.</p> <p>-Night shift short one CNA.</p> <p>-2/11/24 Day shift short one CNA.</p> <p>-Evening shift after 7:00 P.M. short four CNAs.</p> <p>-Night shift short one CNA.</p> <p>-2/17/24 Day shift short three CNAs.</p> <p>-Evening shift after 7:00 P.M. short seven CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-2/18/24 Day shift short three CNAs.</p> <p>-Evening shift after 7:00 P.M. short seven CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-2/24/24 Day shift short four CNAs.</p> <p>-Evening shift after 7:00 P.M. short seven CNAs.</p> <p>-Night shift short one CNA.</p> <p>-2/25/24 Day shift short one Certified Medication Technician (CMT) and three CNAs.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Evening shift short five CNAs.</p> <p>-Night shift short one CNA.</p> <p>1D. Review of the Daily Staffing Sheets for March 2024 showed the following shortages for weekend staffing:</p> <p>-3/2/24 Day shift short two CNAs.</p> <p>-Evening shift short five CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-3/3/24 Day shift short one CNA.</p> <p>-Evening shift short five CNAs.</p> <p>-Night shift short three CNAs.</p> <p>-3/9/24 Day shift short two CNAs.</p> <p>-Evening shift short three CNAs.</p> <p>-Night shift short three CNAs.</p> <p>-3/10/24 Day shift short one CNA.</p> <p>-Evening shift short one CMT and two CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-3/16/24 Day shift short two CNAs.</p> <p>-Evening shift short three CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-3/17/24 Day shift short two CNAs.</p> <p>-Evenings short five CNAs.</p> <p>-Night shift short one Nurse and two CNAs.</p> <p>-3/23/24 Day shift short two CNAs.</p> <p>-Evening shift after 7:00 P.M. short one Nurse and five CNAs.</p> <p>-3/24/24 Day shift short three CNAs.</p> <p>(continued on next page)</p>		

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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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Evening shift short five CNAs.</p> <p>-Night shift short one CNAs.</p> <p>3/30/24 Day shift short one CNA.</p> <p>-Evening shift short two CNAs.</p> <p>-Night shift short four CNAs.</p> <p>-3/31/24 Day shift short six CNAs.</p> <p>-Evening shift short seven CNAs.</p> <p>-Night shift short one CNA.</p> <p>2A. Review of the CMS PBJ for the period of April 1, 2024 through June 30, 2024 showed the report was triggered for excessively low weekend staffing.</p> <p>2B. Review of the Daily Staffing Sheets for April 2024 showed the following shortages for weekend staffing:</p> <p>-4/6/24 Day shift short four CNAs.</p> <p>-Evening shift short four CNAs.</p> <p>-Night shift short one CNA.</p> <p>-4/7/24 Day shift short five CNAs.</p> <p>-Evening shift short four CNAs.</p> <p>-4/13/24 Day shift short two CNAs.</p> <p>-Evening shift short seven CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-4/14/24 Day shift short four CNAs.</p> <p>-Evening shift after 8:00 P.M. short six CNAs.</p> <p>-Night shift short one CNA.</p> <p>-4/20/24 Evening shift short four CNAs.</p> <p>-4/21/24 Day shift short two CNAs.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Evening shift after 7:00 P.M. short three CNAs.</p> <p>-4/27/24 Evening shift short three CNAs.</p> <p>-Night shift short one CNA.</p> <p>-4/28/24 Day shift short two CNAs.</p> <p>-Evening shift short three CNAs.</p> <p>2C. Review of the Daily Staffing Sheets for May, 2024 showed the following shortages for weekend staffing:</p> <p>-5/4/24 Day shift short one CNA.</p> <p>-Evening shift after 7:00 P.M. short four CNAs.</p> <p>-5/5/24 Evening shift after 8:00 P.M. short six CNAs.</p> <p>-5/11/24 Day shift short two CNAs.</p> <p>-Evening shift after 7:00 P.M. short one nurse, after 8:00 P.M. short one CMT and six CNAs.</p> <p>-5/12/24 Day shift short two CNAs.</p> <p>-Evening shift after 7:00 P.M. short one Nurse, one CMT and six CNAs.</p> <p>-5/18/24 Evening shift after 7:00 P.M. short six CNAs.</p> <p>-5/19/24 Evening shift after 7:30 P.M. short four CNAs.</p> <p>-Night shift short two CNAs.</p> <p>5/25/24 Day shift after 12:00 P.M. short two CNAs.</p> <p>-Evening shift short four CNAs.</p> <p>-Night shift short two CNAs.</p> <p>5/26/24 Day shift short three CNAs.</p> <p>-Evening shift short five CNAs.</p> <p>-Night shift short one CNA.</p> <p>2D. Review of the Daily Staffing Sheets for June, 2024 showed the following shortages for weekend staffing:</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-6/1/24 Day shift short three CNAs.</p> <p>-Evening shift short five CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-6/2/24 Day shift short two CNAs.</p> <p>-Evening shift short five CNAs.</p> <p>-6/8/24 Day shift short three CNAs.</p> <p>-Evening shift after 7:00 P.M. short five CNAs.</p> <p>-Night shift short one CNA.</p> <p>-6/9/24 Day shift short five CNAs.</p> <p>-Evening shift short six CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-6/15/24 Evening shift after 6:30 P.M. short five CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-6/16/24 Day shift short one CNA.</p> <p>-Evening shift after 7:00 P.M. short one Nurse, after 8:00 P.M. short seven CNAs.</p> <p>-6/22/24 Day shift short four CNAs.</p> <p>-Evening shift after 7:00 P.M. short four CNAs.</p> <p>-6/23/24 Day shift short five CNAs.</p> <p>-Evening shift short five CNAs.</p> <p>-Night shift short two CNAs.</p> <p>-6/29/24 Day shift short one CNA.</p> <p>-Evening shift short four CNAs.</p> <p>-6/30/24 Day shift after 12:30 P.M. short three CNAs.</p> <p>-Evening shift short three CNAs.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Night shift short two CNAs.</p> <p>3. During an interview on 3/14/25 at 8:58 A.M. the Staffing Coordinator said:</p> <ul style="list-style-type: none"> <li>-The was not always enough staff to have the quota needed for staffing the floors.</li> <li>-They try to ask people to come in to work extra or to work a double.</li> <li>-Sometimes the managers would work on the floors.</li> <li>-He/She did not have any documentation if the managers helped out on the floors.</li> <li>-They were always advertising for more help.</li> <li>-He/She was always to staff the nursing units with the following amount of staff:</li> <li>-Day shift four Nurses, four CMTs, and 13 CNAs.</li> <li>-Evening shift three or four Nurses, four CMTs, and 13 CNAs.</li> <li>-Night shift three Nurses, and eight CNAs, no CMTs.</li> <li>-The Staffing Coordinator would tell the DON if they needed more staff.</li> </ul> <p>4. Review of Resident #10's face sheet showed he/she was admitted on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Traumatic Brain Injury (a brain dysfunction caused by a violent blow to the head).</li> <li>-Lack of coordination.</li> <li>-Heart Failure (a condition in which the heart does not pump blood effectively).</li> <li>-Muscle Weakness.</li> <li>-Need for assistance with personal cares.</li> </ul> <p>Review of the resident's Quarterly Minimum Data Set (MDS) dated [DATE] showed:</p> <ul style="list-style-type: none"> <li>-He/She was cognitively intact.</li> <li>-Staff were to use the mechanical lift to transfer him/her from bed to wheelchair.</li> </ul> <p>Review of the resident's Care Plan dated 2/19/25 showed:</p> <ul style="list-style-type: none"> <li>-He/She had a self care deficit.</li> </ul> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-He/She required the Mechanical Aid Hoyer (a mechanical device that would safely transfer a person from one place to another) lift for transfers. A minimum of two staff members must complete transfers.</p> <p>During an interview on 3/14/25 at 10:00 A.M. the resident said:</p> <p>-Many times there was not enough staff on the weekends to do cares.</p> <p>-He/She needed help to get out of bed with a hoyer lift and two staff.</p> <p>-Many times on the weekend staff does not get him/her out of bed until 2 P.M. and she likes to get up to eat breakfast.</p> <p>-If there was not enough staff meals were served late.</p> <p>5. During an interview on 3/14/25 at 10:20 A.M. CNA F said:</p> <p>-The facility was short staffed almost every weekend.</p> <p>-Some of the resident's cares were not done when they should have been like moving them out of bed especially if it took two staff members like using a hoyer lift.</p> <p>-The facility has asked him/her to work extra about five times a month.</p> <p>-He/She has picked up extra shifts when he/she was able to but sometimes they were still short staffed.</p> <p>During an interview on 3/14/25 at 10:30 A.M. CNA A said:</p> <p>-Many times on the weekends they were short staffed.</p> <p>-He/She was not always able to get cares done when they were short staffed.</p> <p>-Sometimes the residents did not get a bath when they were scheduled to.</p> <p>-They try to offer a bath on a different day.</p> <p>-Evening weekend staff was short staffed maybe twice a month.</p> <p>-Night shift was short staffed more than twice a month.</p> <p>During an interview on 3/14/25 at 11:10 A.M. Registered Nurse (RN) A said:</p> <p>-On the weekends they were short staffed at least once a month.</p> <p>-Evening weekends were short every other weekend.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-When they were short residents cares were delayed such as assistance with feeding and a few times baths were skipped.</p> <p>-He/She was asked to work extra every week.</p> <p>During an interview on 3/14/25 at 2:25 P.M. the Director of Nursing (DON) said:</p> <p>-He/She was not aware there was not enough staff according to the PBJ.</p> <p>-The payroll sheets were sent to CMS by someone in the Corporate Office.</p> <p>-He/she did not monitor the PBJ reports.</p> <p>-If they were triggered for low staff that was something the Administrator should have taken care of.</p> <p>-If there was not enough staff on the Daily Staffing sheets then the Staffing Coordinator would notify him/her.</p> <p>-If they were notified that there was not sufficient staff the Managers would help out on the floors.</p> <p>-There was no documentation if Manager helped out with Nursing tasks.</p> <p>-If they were short staffed the facility offered incentives, posted open shifts, and were continuously hiring more staff.</p> <p>-He/She had not been notified by the nursing staff that resident cares were not done because they did not have enough staff.</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39469</p> <p>Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident # 12) had received dental care out of 29 sampled residents. The facility census was 140 residents.</p> <p>Review of the facility's undated policy, Dental Services, showed:</p> <ul style="list-style-type: none"> <li>-All residents would receive appropriate oral cares if applicable on a daily basis.</li> <li>-It was the responsibility of each staff member within the nursing department to have ensured good oral care for each resident.</li> <li>-Assessment of the oral cavity and teeth was to have been performed upon admission and as necessary.</li> <li>-Observe mouth for any adverse conditions such as bleeding, swelling, unusual mouth odor or any complaint of pain or discomfort.</li> <li>-Note any such condition in the resident's chart and report the problem to the charge nurse.</li> <li>-Refer and or assist residents to obtain dental services as indicated for routine and emergency dental care including making appointment for the resident, if needed or requested and arranging transportation to and from the dentist's office.</li> <li>-Routine services included but were not limited to; <ul style="list-style-type: none"> <li>-Annual inspections.</li> <li>-Dental cleaning, x-rays as needed.</li> <li>-Smoothing of broken teeth.</li> </ul> </li> <li>-Emergency dental services included but were not limited to: <ul style="list-style-type: none"> <li>-Acute or intolerable pain in teeth, gums, or palate.</li> <li>-Broken or damaged teeth.</li> </ul> </li> </ul> <p>1. Review of Resident #12's face sheet showed he/she had originally admitted to the facility on [DATE], readmitted on [DATE], with the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Severe protein-calorie malnutrition (a condition in which a person does not consume enough protein and calories to meet their body's needs).</li> </ul> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Hypokalemia, (a blood level that was below normal in potassium that could result in fatigue, muscle cramps, and abnormal heart rhythms).</p> <p>-Vitamin D deficiency (not getting enough vitamin D from foods or sunlight).</p> <p>-The facility had listed a dentist under care providers.</p> <p>Review of the resident's Dental Note, dated 1/17/23 showed:</p> <p>-Per the resident's request a limited intraoral (within the mouth), assessment was completed.</p> <p>-The resident had root fragments fractured at or below gumline.</p> <p>-Lone remaining tooth was in a poor state.</p> <p>-The resident had requested edentulation (teeth pulled) and dentures made.</p> <p>-A surgical access may have been indicated to remove residual fragments.</p> <p>-This should have been accomplished under a controlled setting for the safety of the patient.</p> <p>-Once (teeth) were removed and patient was well healed, an on site denture fabrication (denture impressions made) by the Dentist was possible.</p> <p>-Referral as noted to an Oral Surgery at nearby hospital.</p> <p>Review of the resident's Re-Admission Evaluation, dated 9/13/24 showed:</p> <p>-He/She was on a regular diet/mechanical soft (foods that were soft easy to chew and swallow, requiring minimal chewing) with chopped meat.</p> <p>-The evaluation did not address broken or missing teeth.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning) dated 1/8/25 showed:</p> <p>-He/She was moderately cognitively impaired.</p> <p>-Was at risk for malnutrition.</p> <p>-No natural teeth or tooth fragments was not checked.</p> <p>Review of the resident's care plan, dated 1/31/25 showed:</p> <p>-He/She had a self care deficit.</p> <p>-Staff was to assist with oral cares every shift.</p> <p>(continued on next page)</p>		

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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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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had the potential nutritional problem and was at risk for malnutrition.</p> <p>-Staff was to explain and reinforce to the resident the importance of maintaining the diet ordered.</p> <p>-Staff was to encourage the resident to comply, explain consequences of refusal such as malnutrition risk factors.</p> <p>-There was no documentation which addressed the resident's broken or missing teeth.</p> <p>Review of the resident's March 2025 Physician's Order Sheet (POS) showed:</p> <p>-Regular diet, regular texture, thin consistency.</p> <p>-There was no order to see the dentist.</p> <p>Record review of the resident's electronic medical record on 3/11/25 showed no information regarding dental services regarding teeth extractions and dentures.</p> <p>Observation and interview with the resident on 3/11/25 at 10:11 A.M. showed:</p> <p>-The resident only had one tooth on the bottom of his/her mouth.</p> <p>-He/She said he/she has only had one tooth on the bottom of his/her mouth for a couple of years.</p> <p>-He/She had not seen the dentist in the last year.</p> <p>-He/She said it was hard to eat regular food and most of the time his/her mouth hurts.</p> <p>-Observation of the resident's breakfast tray showed he/she had been served a regular tray.</p> <p>-He/She had told a staff member a couple of times that he/she would like to have his/her one tooth pulled as well as the broken teeth, then get a set of dentures.</p> <p>During an interview on 3/14/25 at 10:10 A.M. Certified Nursing Assistant (CNA) A said:</p> <p>-The resident only had a couple of teeth on the bottom.</p> <p>-The resident had problems eating sometimes.</p> <p>-The resident should have had dentures but did not have any.</p> <p>-He/She had not said anything to the nurse.</p> <p>During an interview on 3/14/25 at 10:20 A.M. CNA F said:</p> <p>-He/She had to help with the resident with oral cares.</p> <p>-He/She only had a couple of teeth on the bottom of his/her mouth.</p> <p>(continued on next page)</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She had problems eating and maybe should have had dentures.</p> <p>-He/She did not know if the resident had seen a dentist.</p> <p>-There was a dentist who came to the facility.</p> <p>-He/She had not said anything to the nurse because the resident had always had teeth issues.</p> <p>During an interview on 3/14/25 at 11:10 A.M. Registered Nurse (RN) A said:</p> <p>-He/She was not aware that the resident was missing any teeth or had any dental issues.</p> <p>-The residents should have been seen by the dentist at least once a year.</p> <p>-If a resident did not have any teeth the facility should have helped them obtain dentures.</p> <p>-The dentist came to the facility monthly.</p> <p>-Nursing should have documented in the resident's chart if he/she was missing teeth.</p> <p>-He/She did not see an order for the resident to see the dentist.</p> <p>-The Director of Nursing (DON) was ultimately responsible for ensuring the residents received the cares they needed.</p> <p>During an interview on 3/14/25 at 2:55 P.M. the DON said:</p> <p>-When a resident came into the facility or came back to the facility a complete head to toe assessment should have been performed by the admitting nurse, which should have included looking into their mouth and documenting the findings on the assessment sheet.</p> <p>-If a resident was missing teeth that should have been documented also on the resident's care plan.</p> <p>-The resident should have seen a dentist twice a year.</p> <p>-He/She would have expected the nursing staff to know if a resident was missing teeth especially if they had to help the resident do oral cares.</p> <p>-The resident should have seen the dentist within the first six months that they were admitted to the facility.</p> <p>-The dentist had seen the resident and the Social Worker (SW) should have made the appointment at the hospital to have his/her teeth pulled and fitted for dentures, this was missed somehow.</p> <p>-He/She would have expected the SW to have made the appointment for the resident with the oral surgeon within a couple of days.</p> <p>(continued on next page)</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There should have been an order to see the Dentist if the Dentist was on the face sheet listed as a provider and it was not done.</p> <p>-He/She was ultimately responsible for ensuring residents received the cares they needed and appointments were kept.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>21003</p> <p>Based on observation, interview and record review, the facility failed to use the liquid to maintain the nutritive value of pureed carrots and pureed chicken for residents who received pureed diets. This deficient practice potentially affected residents who received pureed diets. The facility also failed to ensure the temperature of carrots and ham was maintained throughout the meal service for residents who consumed food out of the kitchen. The facility census was 140 residents.</p> <p>Review of the facility's Therapeutic Diet policy and procedure dated 12/2020, showed the purpose was to ensure that the facility provided therapeutic diets to residents that meet nutritional guidelines and physician orders. It showed:</p> <ul style="list-style-type: none"> <li>-The Nutrition Service Manager was responsible for ensuring the correct type and amount of food is purchased to meet the needs of residents receiving therapeutic diets.</li> <li>-The Nutrition Services Manager was responsible for ensuring each food item is pureed and served separately for a pureed diet per the menu and recipe.</li> </ul> <p>Review of the facility Food Temperatures policy and procedure dated 12/2020, showed the purpose was to provide the nutrition services department with guidelines for food preparation and service temperatures. The policy showed:</p> <ul style="list-style-type: none"> <li>-When measuring food temperature .take the temperature of each pan of product before serving.</li> <li>-The acceptable serving temperatures for vegetables, and pureed foods showed at or above 135 degrees Fahrenheit.</li> <li>-If temperatures are not at acceptable levels and cannot be corrected at the time of the meal service, an appropriate substitution should be implemented.</li> </ul> <p>Review of the facility recipe for completing pureed vegetables and meats, showed the facility could use vegetable broth or vegetable paste mixed with water to add to the pureed vegetable. It showed before chicken broth or paste mixed with water prior to adding to the puree for beef, chicken or pork puree.</p> <p>1. Observation on 3/12/25 at 10:21 A.M., showed:</p> <ul style="list-style-type: none"> <li>-Cook A was prepping the lunch menu food items.</li> <li>-On the steam table were pureed food items (chicken, carrots, and mashed potatoes).The steam table was turned on and there was steam coming from the cells on the table indicating it was in working order.</li> <li>-Cook A took the ham out of the oven and regular food items, that had already been prepared.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Cook A was chopping ham for the mechanical (ground meat) diets. When he/she was done, he/she placed the food items on the steam table.</p> <p>-At 11:03 A.M., [NAME] A had placed ham slices, cooked carrots, mashed potatoes, mechanical ham, gravy, pureed chicken, pureed carrots, cream of chicken soup with chicken chunks, and chili on the steam table. [NAME] A placed serving utensils in all food items and then took out baked potatoes from the oven and placed them on steam table .</p> <p>-At 11:15 A.M. [NAME] A began serving plates, to include pureed diets, from the steam table without taking the temperatures of the food items prior to serving.</p> <p>-At 12:10 P.M., showed all meals were served. The test tray showed the temperatures of the following food items: pureed carrots 140 degrees Fahrenheit, pureed chicken 139 degrees Fahrenheit, mashed potatoes 138 degrees Fahrenheit, Chili 139 degrees Fahrenheit, baked potato 135 degrees Fahrenheit, chicken soup 130 degrees Fahrenheit, carrots 111 degrees Fahrenheit and ham slices 104 degrees Fahrenheit.</p> <p>-The test of the pureed carrots and pureed chicken showed the texture was that of mashed potatoes, but the taste was bland and without flavor or seasoning.</p> <p>During an interview on 3/12/25 at 12:10 P.M., the Dietary Manager said:</p> <p>-The temperatures of the carrots and ham were below the acceptable serving temperature of 120 degrees Fahrenheit.</p> <p>-Either he/she or the [NAME] usually take the temperatures of the food right before serving.</p> <p>-He/She didn't know if they were taken today before the service, or why the temperatures were not taken before the service started.</p> <p>-At 12:20 P.M. the Dietary Manager tasted the pureed carrots and chicken and said the puree tasted bland and without any seasoning.</p> <p>-He/She said they did not usually taste the pureed foods, but they should taste like the food item being served and should have some seasoning or butter to add to the flavor.</p> <p>-They should add broth, chicken base or milk as the liquid for making the puree.</p> <p>During an observation and interview on 3/12/25 at 12:21 P.M., with [NAME] A and the Dietary Manager showed [NAME] A tasted the pureed carrots and chicken and said:</p> <p>-The pureed carrots and chicken had no seasoning and was not good.</p> <p>-He/She used water as the liquid to add to the puree and was not aware that he/she should have used chicken base, broth or milk.</p> <p>-He/She had not looked at the recipe.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The Dietary Manager said they can add honey, butter, broth to season the puree and should not use water. He/She said they have chicken paste they could have added to the puree to thin and add flavor to it.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>21003</p> <p>Based on observation, interview and record review, the facility failed to ensure kitchen was kept clean and kitchen devices were free from caked on grease, soil and food debris. This deficient practice potentially affected all residents who ate out of the kitchen. The facility census was 140 residents.</p> <p>1. Observation on 3/12/25 at 10:21 A.M., showed:</p> <ul style="list-style-type: none"> <li>-The dishwasher had yellowish, dried on food debris on outside of washer.</li> <li>-The tray containing covered bowls of dry cereal on the prep table in front of the oven showed spilled cereal debris on and around the tray and floor.</li> <li>-The toaster on top of the prep table had dried food debris and grease on the outside of the toaster. The mechanical parts inside the toaster had food debris that was caked on the roller mechanism.</li> <li>-The convection oven had baked on grease and debris on the knobs, panel front and sides of the oven and there was dark brown and black, thick, greasy debris on the top of the oven and backsplash.</li> <li>-The well cookers (two) showed the outside of the right cooker was soiled with dried food debris.</li> <li>-The floor throughout the kitchen showed soil and food debris and stains that were over time.</li> </ul> <p>During an interview on 3/12/25 at 10:42 A.M., [NAME] A said:</p> <ul style="list-style-type: none"> <li>-They clean the wells daily and they use them for cooking eggs.</li> <li>-At this time he/she looked at the pots and said they needed to be wiped down.</li> <li>-They had a cleaning schedule, but the dietary staff were supposed to clean after every meal and cleaning consisted of making sure everything-countertops, shelves, and cooking equipment, were all wiped down and cleaned off before they start the next meal.</li> <li>-The final cleaning occurred after the last meal of the day.</li> <li>-Cook A used a wet scrubber to scrub the wells and then wiped them down.</li> </ul> <p>During an interview on 3/12/25 at 12:31 P.M., the Dietary Manager:</p> <ul style="list-style-type: none"> <li>-Looked at the tray with food debris and said the dietary staff should have cleaned this off after breakfast.</li> <li>-The cook and dietary staff were supposed to wipe everything (all kitchen equipment and countertops) down after each meal.</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The cook was responsible for cleaning the stove and they should do a deep cleaning at least weekly.</p> <p>-The cook or dietary staff should wipe down the toaster after each use, but they had not taken the toaster roller apart to clean it thoroughly and that should be done at least weekly.</p> <p>-The floors were dirty and they were waiting for the cleaning team to come in to clean the floors. He/ She said the dietary staff sweep and mop at the end of the day, but the floors needed a deep cleaning and they were just waiting for the vendor to come in.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21003</p> <p>Based on observation, interview and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) by expanding the use of gowns and gloves during high-contact resident care activities) were implemented for one sampled resident (Resident #82) with a foot wound and receiving intravenous (IV-a way of giving a drug or other substance through a needle or tube inserted into a vein) antibiotic therapy; and out of 29 sampled residents. The facility census was 140 residents.</p> <p>Review of the facility's Standard and Enhanced Precautions policy and procedure dated 4/1/24, showed the purpose was to ensure the use of appropriate personal protective equipment (PPE-protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) to improve infection control as required in the care of residents. The policy showed:</p> <ul style="list-style-type: none"> <li>-Enhanced barrier precautions should be used for any residents who meet the above criteria wherever they reside in the facility.</li> <li>-EBP refers to an infection control intervention designed to reduce transmission of MDRO organisms that employs targeted gown and glove use when contact precautions do not otherwise apply and/or transmission such as presence of a medical device and wounds.</li> <li>-For residents whom EBP is indicated, EBP should be used when performing the following high contact resident care activities-dressing, bathing, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care or any skin opening requiring a dressing.</li> <li>-EBP are intended to be in place for the duration of the resident's stay in the facility or until resolution of the wound or discontinuation of the medical device that placed them at high risk.</li> <li>-Use of EBP are not recommended when performing transfers in common areas such as dining or activity rooms where contact is anticipated to be shorter in duration and not in the resident's environment (room).</li> </ul> <p>1. Review of Resident #82's Face Sheet showed the resident was admitted on [DATE], with diagnoses including stroke with paralysis, diabetes, high blood pressure, seizures, malnutrition, peripheral vascular disease (a circulatory condition characterized by the narrowing, blockage, or spasm of blood vessels outside the heart and brain, leading to reduced blood flow and potential tissue damage) and aphasia (a communication disorder that affects the ability to speak and write).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 1/24/25, showed the resident:</p> <ul style="list-style-type: none"> <li>-Was alert with significant memory problems.</li> <li>-Was totally dependent on staff for bed mobility, transfers, toileting, bathing dressing, eating and mobility.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Did not show the resident had any wounds, but showed the resident had ointments and dressings that were applied during the look back period.</p> <p>Review of the resident's Care Plan dated 2/14/25, showed the resident had a vascular wound (a wound on the skin that develops due to poor blood circulation) to his/her right heel due to vascular insufficiency (poor blood circulation). Interventions showed:</p> <ul style="list-style-type: none"> <li>-Follow physician's orders. Monitor/document side effects and effectiveness.</li> <li>-Inspect the resident's feet daily, especially between the toes. Report changes to the nurse.</li> <li>-Monitor/document wound: size, depth, margins, signs and symptoms of infection. Document progress in wound healing on an ongoing basis. Notify physician as indicated.</li> <li>-Observe extremities for signs/symptoms of poor tissue improvement. Document changes Report significant findings to physician.</li> <li>-Teach the resident/family/caregiver to avoid risks for skin injury and decreased circulation.</li> <li>-Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid that leaks out of blood vessels) and any other notable changes or observations.</li> </ul> <p>Review of the resident's Treatment Administration Record (TAR) dated 2/2025 and 3/2025, showed treatment orders for:</p> <ul style="list-style-type: none"> <li>- Wound care to right heel: clean with normal saline (salt water)/wound cleaner, pat dry, apply calcium alginate to wound bed, cover with dry dressing daily and as needed every day shift and every 8 hours as needed (2/21/25).</li> </ul> <p>-The TAR showed the resident was receiving treatment as ordered daily.</p> <p>-There were no physician's orders for EBP.</p> <p>Review of the resident's Physician's Order Sheet (POS) updated 3/11/25, showed physician's orders for:</p> <ul style="list-style-type: none"> <li>-Enhanced Barrier Precautions related to the resident's right heel: Staff members will wear a clean gown and gloves while performing high contact resident care activities to include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices every shift for peripheral vascular disease (3/11/25).</li> </ul> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation 3/11/25 at 10:14 A.M., showed there was no EBP sign or PPE on the door or around it. The resident was in bed and there was a bandage on his/her right ankle (undated) and the resident had a dressing on his upper left arm that was dated 2/26/25 (IV access area). There was an IV pole beside his bed but there was no bag. At 10:17 A.M., Certified Nursing Assistant (CNA) D came in to check on the resident. He/She was not wearing any PPE. He/She adjusted the resident's position in bed, rolled the resident to the side to check him/her for incontinence, straightened the linens and bed pad. He/She then gathered the resident's trash and soiled linen and left the room.</p> <p>During an interview on 3/11/25 at 10:21 A.M. CNA D said:</p> <ul style="list-style-type: none"> <li>-The resident was on an IV for an infection in his/her wound.</li> <li>-He/She was not sure how often the nurse changed the dressing on the resident.</li> <li>-He/She did not always work with the resident.</li> </ul> <p>Observation on 3/12/25 at 2:03 P.M., showed there was no EBP sign on the door and no PPE for staff to use when providing care to the resident. The resident was in his/her room in bed. The resident's right ankle was wrapped with dressing dated 3/12/25. The resident no longer had a dressing on his/her arm where the IV access was.</p> <p>Observation and interview on 3/13/25 at 9:42 A.M., showed there was no EBP sign on the resident's door nor was there PPE for staff to use when providing direct care to the resident. The resident was laying down in his bed and the dressing was on his/her right foot. At 9:45 A.M., CNA E went to the resident's room and placed a EBP sign on the resident's door and began hanging a rack with PPE supplies on the door. CNA E said:</p> <ul style="list-style-type: none"> <li>-He/She had just received the updated wound report and went to place this on the resident's door.</li> <li>-The resident has had a wound, but there was no EBP sign and PPE on the resident's door until now.</li> <li>-He/She said they were to put the signage and PPE on the door whenever a resident had a wound, ostomy (any artificial opening in the body), IV or infection and staff were to put PPE on whenever they interacted with the resident.</li> <li>-He/She did not know why the resident had not had an EBP sign on the door or PPE available prior to today.</li> </ul> <p>Observation and interview on 3/13/25 at 9:47 A.M., showed CNA D went into the resident's room as CNA E was hanging the EBP sign and PPE on the resident's door. CNA D did not put on a gown or gloves before or upon entering the resident's room and checked on the resident. He/She took a clean cloth and wiped the resident's face then gathered his/her trash and sanitized his/her hands before leaving the resident's room. CNA D said:</p> <ul style="list-style-type: none"> <li>-He/She was unaware that the resident was supposed to be on EBP and the resident did not have a sign on the door or PPE prior to just now.</li> </ul> <p>(continued on next page)</p>		

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Hilltop at Blue River, The		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Those residents who were on EBP had signs on the door and PPE so the nursing staff knew they needed to put on gowns and gloves when providing care and interacting with the resident.</p> <p>-No one had communicated that the resident should have been on EBP since he/she had a wound.</p> <p>-The resident has had the wound on his/her foot for a couple weeks and he also had the IV, but it was not communicated that he/she was also on EBP, so he/she provided cares to the resident as he/she normally would without putting on PPE.</p> <p>-Usually if a resident had a wound or any openings on the body, they were supposed to wear PPE.</p> <p>-He/She had just transferred the resident into bed so that the nurse could do his/her wound care but he/she had not worn a gown or gloves.</p> <p>-Now that the resident has the EBP sign and PPE he/she would put the PPE on upon entering the resident's room.</p> <p>During an interview on 3/13/25 at 1:06 P.M., Certified Medication Technician (CMT) A said:</p> <p>-EBP signs are on the doors with the PPE for any resident with any open orifices or wounds.</p> <p>-They are supposed to put on PPE if they are going in to provide care to the resident.</p> <p>-The resident has had wounds for a while on his/her toes and on his/her foot that have been getting treated daily.</p> <p>-He/She had not seen nursing staff wearing PPE when providing care to the resident.</p> <p>-The resident probably should have had the EBP sign on the door and PPE available for the staff to wear prior to this week.</p> <p>During an interview on 3/14/25 at 2:26 P.M., the Director of Nursing (DON) said:</p> <p>-Residents on EBP are those residents who have openings, any kind of devices, wounds, catheters, ostomies IV and residents on dialysis.</p> <p>-The protocol is to assess the resident, put up the EBP equipment and sign on the door and they also put the order for EBP on the resident's POS and let the staff know that the resident is on EBP.</p> <p>-Staff has been educated on EBP protocol.</p> <p>-He/She was informed yesterday there was a resident with a wound and the EBP was not in place and should have been. They notified Central Supply who put the EBP in place and put the sign on the door.</p> <p>-Any of the staff can place the EBP sign and PPE for those residents who they have identified.</p> <p>39469</p>		