STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175348	A. BUILDING _____ B. WING _____	C 07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP LODGE HEALTH AND REHABILITATION CENTER	815 N INDEPENDENCE AVENUE, PO BOX 467 BELOIT, KS 67420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #163770, #162916, and #163541. The 2567 was electronically sent to the facility on 07/08/21.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/08/2021

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.

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F 609	Continued From page 1	F 609		

The facility had a census of 58 residents. The sample included four residents, with three reviewed for abuse. Based on observation, record review, and interview, the facility failed to report a physical altercation between Resident (R) 1 and R2 to the State agency.

Findings Included:

- R1's "Physician's Order Sheet" (POS), dated 07/02/21, documented diagnoses of paranoid schizophrenia (psychotic disorder characterized by gross distortion of reality influenced by anxiety or fear to the point of irrational thinking), major depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and mood disorder (emotional state or mood is distorted and interferes with ability to function).

R1's "Quarterly Minimum Data Set" (MDS), dated 05/07/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact), no behaviors, and received antipsychotic medication (class of medications used to treat psychosis and other mental emotional conditions) seven days a week.

R1's "Mood and Behavior Care Plan," dated 06/27/21, directed staff to monitor and record the resident's target behaviors, and notify the physician and mental health staff if R1's behaviors increased or worsened.

R2's "POS," dated 06/04/21, documented diagnoses of psychosis (any major mental disorder characterized by a gross impairment in reality testing), major depression and dementia

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F 609	Continued From page 2	F 609		

with behaviors (progressive mental disorder characterized by failing memory and confusion).

R2's "Quarterly MDS", dated 06/03/21, documented the resident had a BIMS score of eight (moderately impaired), no behaviors, and received antipsychotic medication seven days a week.

R2's "Mood and Behavior Care Plan," dated 06/11/21, documented the resident had behaviors, confusion, and memory problems related to dementia. The care plan directed staff to monitor and record R2's behaviors, and report increased behaviors to the physician and mental health staff.

R1's "Progress Note," dated 06/27/21 at 11:00 AM, documented R1 pulled R2 out of her wheelchair and hit R2's head several times with a closed fist. The progress note documented staff stopped the altercation, assessed both residents for injuries, and notified the resident's physician.

R1's "Progress Note," dated 06/27/21 at 03:25 PM, documented the Emergency Room (ER) physician ordered the facility to send R1 to a hospital behavioral unit for psychiatric evaluation and treatment.

R2's "Progress Note," dated 06/27/21 at 04:20 PM, documented R2 returned to the facility from the hospital, no head injuries noted, and the physician directed staff to continue Neurological checks (assessment for the function and level of consciousness of the nervous system) every four hours for 24 hours.

The facility lacked documentation staff reported

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the resident to resident altercation to the state agency.

On 07/07/21 at 11:31 AM, observation revealed R1 sat in a wheelchair at a table in the north dining room, and visited with other residents and staff.

On 07/07/21 at 11:55 AM, observation revealed R2 sat in a wheelchair at a table in the south dining room, and visited with other residents and staff.

On 07/07/21 at 08:55 AM, Administrative Nurse D stated the facility should report resident to resident altercations to the State agency within 24 hours.

On 07/07/21 at 11:09 AM, Licensed Nurse (LN) G stated staff observed R1 and R2 interact with each other for months without any signs of conflict or aggression.

On 07/07/21 at 11:15 AM, Certified Nurse Aide (CNA) M stated R1 had lived at the facility for several years and had no history of altercations with other residents.

The facility's "Reporting Procedures" policy, dated October 2017, directed staff to report incidents of abuse and neglect within 24 hours to the State agency, and submit an investigation of the incident within five working days.

The facility failed to report a physical altercation between R1 and R2 to the State agency, placing the residents at risk for continued conflict.