STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a Resurvey conducted at the above named facility on 11/09,10, 12/2020.	S 000		
S3082 SS=F	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 The facility reported a census of 1 resident which was included in the sample. Based on record review and interview the administrator failed to ensure designated staff ensured 1 (#119) of 1 resident's functional capacity screen accurately reflected the resident's functional status at the time of screening on that resident's screening form. Findings included: - Review of resident #119's medical record revealed she admitted to the facility on 12-1-17 with diagnoses of osteoarthritis, bilateral knee pain, hypertension, and chronic kidney disease. Review of the residents functional capacity screen (FCS) dated 4-1-19 revealed the resident was independent with toileting and eating and needed physical assistance with transfers and walking/mobility. It also revealed the resident required physical assistance with money	S3082		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3082	Continued From page 1 management, medications and medical treatments, and was not able to manage her own transportation. The resident was usually continent of bladder and able to communicate without difficulty. The FCS failed to screen the residents functional status related to bathing, dressing, meal preparation, money management and laundry/housekeeping. IT also failed to assess the residents functional cognitive status. On 11-9-20 at 3:48 PM licensed nursing staff B confirmed the FCS was incomplete and therefor did not accurately reflect the residents functional status. The administrator failed to ensure designated staff completed resident #119's functional capacity screen to accurately reflect the resident's functional status at the time of the screening.	S3082		
S3085 SS=F	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3085	Continued From page 2 payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a)(1) The facility reported a census of 1 resident which was included in the sample. Based on interview and record review the administrator failed to ensure the development of a written negotiated service agreement for 1 (#119) of 1 resident based on the resident's functional capacity screening, service needs, and preferences in collaboration with the resident which failed to include services related to dressing, and fall prevention. Findings included: - Review of resident #119's medical record revealed he/she admitted to the facility on 12-1-17 with diagnoses of osteoarthritis, bilateral knee pain, hypertension, and chronic kidney disease. Review of the residents functional capacity screen (FCS) dated 4-1-19 revealed the resident was independent with toileting and eating and needed physical assistance with transfers and walking/mobility. It also revealed the resident required physical assistance with money management, medications and medical treatments, and was not able to manage her own transportation. The resident was usually continent of bladder and able to communicate without difficulty. The FCS identified the resident had a problem/risk for falls.	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3085	Continued From page 3 Review of the negotiated service agreement / health care service plan (NSA/HCSP dated 4-1-19 and last reviewed on 9-18-20 lacked services related to the need for physical assistance with walking/mobility and identified the resident was independent with transfers. The NSA/HCSP lacked information regarding fall prevention and the service of staff assisting with morning dressing. During an interview on 11-9-20 at 3:52 PM licensed nursing staff B reported she did not think staff assisted the resident with dressing in the morning, including helping him/her with putting on shoes. Certified staff J walked by the office at that time and licensed nurse B asked staff J if she helped resident #119 with getting dressed. Certified staff J reported she helped the resident put on his/her shoes every morning when she put on his/her ted hose. The administrator failed to ensure the development of a written negotiated service agreement for 1 (#119) of 1 resident based on the resident's functional capacity screening, service needs, and preferences in collaboration with the resident which failed to include services related to dressing, and fall prevention.	S3085		
S3200 SS=F	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3200	Continued From page 4	S3200		

of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met:
(1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility.
(2) Medication aides shall not administer medication through the parenteral route.

This REQUIREMENT is not met as evidenced by:
K.A.R 26-41-305(d)

The facility reported a census of 1 resident which was included in the sample. Based on interview and record review the facility failed to administer medications for 1 (#119) of 1 resident in accordance with medical care providers orders and professional standards of practice.

Findings included:

- Review of resident #119's medical record revealed she admitted to the facility on 12-1-17 with diagnoses of osteoarthritis, bilateral knee pain, hypertension, and chronic kidney disease.

Review of the resident's functional capacity screen (FCS) dated 4-1-19 revealed the resident needed physical assistance with medications and medical treatments. The FCS lacked assessment of the resident's cognitive status.

Review of the resident's negotiated service agreement/health care service plan (NSA/HCSP) dated 4-1-19 and last reviewed on 9-18-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3200	Continued From page 5	S3200		

revealed staff managed the resident's medications, the certified medication aid applied lotion to the resident's legs and feet at bedtime with medication pass. The NSA/HCSP did not address if staff or resident managed his/her medical treatments.

Review of the resident's electronic record included a signed physicians order dated 12-27-18 for the resident to try appropriate size salon pas 4% patch for maximum of 12 hours for heel pain.

Review of the physicians signed orders dated 1-17-19 included the application of the salon pas 4% lidocaine patch for heel pain.

Review of the resident's medication/treatment administration records (MAR) from January 2019 to November 2020 the resident had not received the salon pas patches as ordered. The patch was not listed on the MAR's for staff to administer. During this time frame the resident received scheduled Lortab for pain. The resident's pain level averaged a level of 5 or 6 most of the time.

Review of the resident's nurses notes revealed the following:
12-27-18 - Order given for resident to try appropriate size salon pas 4% patch on for maximum of 12 hours for heel pain by PCP.

During an interview on 11-10-20 at 9:25 AM Licensed nursing staff B looked in the computer to see what she could find about the Salon pas order. As nurse B looked Licensed nursing staff C also looked and then showed nurse B something in the system on the orders. Nurse C then stated that the order is in the system to apply

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3200	Continued From page 6 Salon pas 4% one time a day for 12 hours but the person that put it in the computer did not have it inputted so that it would show up on the medication or treatment records. On 11-10-20 at 9:40 AM Licensed nurse C returned to the office after speaking to certified staff J and confirmed that the resident had not been getting the salon applied to his/her heels. The administrator failed to ensure staff administered medications according to physician orders.	S3200		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by:	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3280	Continued From page 7 KAR 26-41-104(d)(3) The facility reported a census of 1 resident. Based on record review and interview for all residents and all facility employees, the administrator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with employees and residents. Findings included: - On 11-10-20 at 9:05 AM review of the facility's emergency management training provided by administrative staff A revealed the facility's staff reviewed the emergency management program for disaster preparedness on 4-19-18, 5-1-18 and again on 5-6-19. The facility then used an electronic method of inservices and the disaster preparedness was reviewed in March of 2020. Review of the record revealed the staff did not receive quarterly reviews of the emergency management disaster preparedness plan. The facility failed to be able to provide any evidence of quarterly reviews of the 8 required potential emergencies/disasters with residents. During an interview on 11-9-20 at 12:25 AM, administrative staff A reported the facility had not done quarterly reviews of the emergency management disaster plan quarterly with residents and staff. 11-10-20 at 12:26 PM surveyor requested a copy of the emergency manage plan policy and procedures specifically related to training/review for residents and facility staff.	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3280	Continued From page 8 For all residents and employees, the administrator failed to ensure emergency preparedness by ensuring quarterly review of the 8 required emergencies/disasters with all staff and residents.	S3280		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207(c) The facility reported a census of 1 residents. The sample included the 1 resident. Based on interview and record review for 1 (#119) of 1 resident and review of 5 newly hired employee records, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105. This failure effected all residents who	S3310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3310	Continued From page 9	S3310		

lived in the residential health care facility.

Findings included:

- Review of resident #119's record revealed he/she admitted to the facility on 12-1-17 with diagnoses of osteoarthritis, bilateral knee pain, hypertension and chronic kidney disease.

Review of the resident's electronic medical record lacked evidence the facility administered an annual TB symptom screen or an annual TB skin test.

On 11-9-20 at 1:45 PM - licensed nursing staff B looked in the immunization book, looked through the resident's electronic record and could not find a TB symptom screen or TB skin test for the resident since May of 2018.

On 11-9-20 at 2:07 PM licensed nursing staff D found in the residents record where the resident had a TB skin test in May of 2018 but could not find a symptom screening form completed in 2019. Staff D stated that they have been doing the symptom screening annually now.

The administrator failed to ensure facility staff remained in compliance with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 by failing to complete a TB symptom screening form or administering a TB skin test for the resident annually.

- Review of 5 newly hired employees file revealed the following:

Certified staff E hired on 12-30-19, received a TB 2 step skin test but did not complete the symptom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE
S3310	Continued From page 10	S3310		

screening questions.
Certified staff F hired on 4-5-20, received a TB 2 step skin test but did not complete the symptom screening questions.
Certified staff G hired on 7-21-20, received a TB 2 step skin test but did not complete the symptom screening questions.
Dietary staff H hired on 9-29-20, received a TB 2 step skin test but did not complete the symptom screening questions.
Licensed nursing staff I hired on 7-28-20, received a TB 2 step skin test but did not complete the symptom screening questions.

On 11-10-20 at-9:48 AM licensed nursing staff B reported the nurse on duty completed the TB tests for new hires and for residents. Licensed nurse B stated the facility had to do an actual skin test upon hire and then we can do the form (screening) yearly. Staff B stated they were no completing the symptom screening form upon hire or upon admission to the facility.

Review of the June 2013 TB guidelines for adult care homes revealed that each new resident and new employee shall have an initial TB symptoms screen that includes the components of the TB symptom screen questionnaire within 7 days of residency or employment.

Surveyor requested a copy of the facilities policy and procedures related to TB testing on 11-9-2020 at 10:05 AM.

For 1 of 1 sampled residents (#119) and 5 of 5 new employees, the administrator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N029004	A. BUILDING: _____ B. WING _____	11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOUSE	505 W ELM, PO BOX 248 BUCKLIN, KS 67834

(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) COMPLETE DATE