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 11/21/2022

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

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F 000	INITIAL COMMENTS The following citations are the result of comlpaint investigation KS00175565. On 11/17/22 at 04:50 PM the facility received a copy of the 'Immediate Jeopardy [IJ] Template" and was notfieid of the IJ for Resident (R) 1. On the evening of 10/10/22 at 07:52 PM R1 had a blood pressure (BP) of 82/60 millimeters of Mercury (mmHg). R1's clinical record lacked evidence of further assessment and physician notification in response to the abnormally low BP. R1's clinical record lacked evidence licensed nursing staff assessed R1's BP from the abnormal low on 10/10/22 through the morning of 10/15/22. On 10/15/22 at 10:36 AM R1's BP was again abnormally low at 82/54 mmHg and R1's clinical record lacked evidence of physician notification and evidence nursing staff initiated any follow up assessment or actions related to the abnormal finding. During this timeframe, 10/14/22 through 10/16/22, R1 was noted with dizziness, nausea, and vomiting. On the afternoon of 10/16/22, approximately six days from the initial abnormal finding, LN H notified R1's physician of R1's condition which included nose bleeds, nausea and vomiting, and new bruising, but failed to report the abnormal blood pressures. Nursing staff did not reassess R1's blood pressure on 10/16/22 or 10/17/22. On 10/17/22, R1's physician assessed him and then sent R1 directly to the emergency department. R1 admitted to the hospital for dehydration. The licensed nursing staff failure to detect, thoroughly assess, and respond to changes in the resident's condition, placed R1 in immediate jeopardy.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/06/2022

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 000	Continued From page 1 On 11/18/22 the facility removed the Immediate Jeopardy by completing the following actions: 1. All nursing staff received education on changes of conditions, physician notification of changes and vital sign parameters. 2. All residents were reviewed for irregularities in condition or vital signs. 3. The incident was reviewed was reviewed by the facility's Quality Assurance and Performance Improvement team. The deficiency remained at a scope and severity of a "D" after implementation of the corrective actions. The 2567 was sent electronically on 12/06/22.	F 000		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		

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§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 66 residents. Based on record review and interview, the facility failed to ensure licensed nursing staff possessed the skills and knowledge necessary to detect and respond to changes in a resident's condition. On the evening of 10/10/22 at 07:52 PM Resident (R)1 had a blood pressure (BP) of 82/60 millimeters of Mercury (mmHg). R1's clinical record lacked evidence of further assessment and physician notification in response to the abnormally low BP. R1's clinical record lacked evidence licensed nursing staff assessed R1's BP from the abnormal low on 10/10/22 through the morning of 10/15/22. On 10/15/22 at 10:36 AM R1's BP was again abnormally low at 82/54 mmHg and R1's clinical record lacked evidence of physician notification and evidence nursing staff initiated any follow up assessment or actions related to the abnormal finding. During this timeframe, 10/14/22 through 10/16/22, R1 was noted with dizziness, nausea, and vomiting. On the afternoon of 10/16/22, approximately six days from the initial abnormal finding, LN H notified R1's physician of R1's condition which included nose bleeds, nausea and vomiting, and new bruising, but failed to report the abnormal blood

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pressures. Nursing staff did not reassess R1's blood pressure on 10/16/22 or 10/17/22. On 10/17/22, R1's physician assessed him and then sent R1 directly to the emergency department. R1 admitted to the hospital for dehydration. The licensed nursing staff failure to detect, thoroughly assess, and respond to changes in the resident's condition, placed R1 in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of heart failure (a condition with low heart output and the body becomes congested with fluid), chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and hypertension (high blood pressure).

The "Admission Minimum Data Set (MDS)," dated 10/02/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of twelve, which indicated moderately impaired cognition. The MDS further documented R1 required limited to extensive assistance of one staff to perform all activities of daily living (ADL) and a diagnosis of hypertension.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 10/02/22, documented staff were to monitor R1 for signs and symptoms of acute mental status changes to help treat the underlying condition.

The "Activities of Daily Living CAA," dated 10/02/22 documented staff were to assist R1 with

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ADL cares as needed, anticipating cares, so that care needs are effectively met. Therapy services were to be used as needed to help increase functional mobility.

The "Renal Failure Care Plan," dated 10/06/22, directed staff to monitor R1 for signs and symptoms of hypovolemia (abnormally low circulating blood volume).

The "High Blood Pressure Care Plan," dated 10/06/22, directed staff to monitor R1 for headache, visual changes, lethargy, irritability, and nausea and vomiting.

The "Admission Note," dated 09/26/22, documented R1 was admitted to the facility and had a sitting blood pressure of 131/83 mmHg (normal range for adults is 120/80)

The "Vital Signs," dated 09/29/22, documented R1's blood pressure was 113/76 mmHg.

The "Vital Signs," dated 10/07/22, documented R1's blood pressure was 110/61mmHg lying.

The "Vital Signs," dated 10/10/22, documented R1's blood pressure was 82/60 mmHg (lying down), taken by LN G. R1's clinical record lacked evidence of further assessment and/or physician notification in response to the abnormally low BP and lacked evidence the low BP was reported to R1's physician.

The "Nurse's Note," dated 10/11/22, documented R1 had complained of being lightheaded when standing/ambulating.

The "Vital Signs," dated 10/15/22, documented

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R1's blood pressure was 82/54 mmHg (lying), taken by LN G. R1's clinical record lacked evidence the staff reported the abnormal BP reading to the physician, and lacked evidence nursing staff initiated any follow up assessment or actions related to the abnormal finding.

The "Communication with Physician Note," dated 10/16/22, documented LN G contacted R1's primary care physician and left a message with his nurse reporting R1 with symptoms of nose bleeds, nausea and vomiting, and new bruising, but did not indicate the nurse reported the abnormal blood pressures.

The EMR for R1 lacked evidence of blood pressures on 10/16/22 and 10/17/22.

The hospital's "History of Present Illness," dated 10/17/22, documented R1 was seen in the clinic that day with recurrent nausea and vomiting. R1 was clinically dry (dehydrated) and sent to the emergency room for intravenous (given directly into the bloodstream via a vein) fluids. R1's metabolic profile showed acute renal (kidney) insufficiency which was felt to be on the basis of dehydration. R1 admitted to the acute hospital for intravenous fluid resuscitation.

On 11/17/22 at 10:30 AM, Consultant GG stated R1 had nausea and vomiting and dizziness for five days prior to his admission to the hospital on 10/17/22, and the facility failed to help R1. Consultant GG stated R1 voiced these complaints to her over the phone, prior to his admission to the hospital.

On 11/17/22 at 11:30 AM, LN I stated skilled residents at the facility get assessments and vital

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signs performed by the nurse in charge, every shift. LN I stated if she had a resident that had a blood pressure 82/60 mmHg she would recheck the blood pressure and notify the physician, or the emergency room if the blood pressure was still low, and assess the resident for symptoms.

On 11/17/22 at 03:00 PM, LN G stated R1 had dizziness and nausea and vomiting. LN G stated R1 did not trust himself to go to the bathroom by himself because he felt unsafe, and he was using his call light to ask for assistance when he needed to get up in his room. LN G stated she had not called R1's primary physician regarding the low blood pressures she had documented because the facility did not have blood pressure parameters to call the physicians. LN G stated looking back she should have used her critical thinking skills and called R1's physician regarding the low blood pressures.

On 11/17/22 at 03:30 PM, Administrative Nurse D verified R1, as a skilled resident in the facility, should have had his vital signs taken twice a shift with assessments, and said the nurse who documented the low blood pressures should have re-assessed R1 and contacted R1's primary care physician.

The facility's "Notification of Changes Policy," dated 02/01/20, documented the purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a change requiring notification. Circumstances requiring notification include significant change in resident's physical, mental, or psychosocial condition such as deterioration of health, mental or psychosocial

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status that may include life-threatening conditions or clinical complications.

The facility's undated "Vital Signs Policy," documented vital signs are indicators of health status, including temperature, pulse, blood pressure, and respiratory rate. Licensed nurses are responsible for knowing the usual range of a resident's vital signs, analyzing, and interpreting routine vital signs, and notifying the physician of abnormal findings. Vital signs shall be performed at least daily for resident's receiving skilled services.

The facility failed to ensure licensed nursing staff possessed the skills, and knowledge necessary to detect and respond to changes in a resident's condition. Staff failed to detect, thoroughly assess, and respond to changes in the resident's condition which placed R1 in Immediate Jeopardy.

On 11/18/22 the facility removed the Immediate Jeopardy by completing the following actions:
1. All nursing staff received education on changes of conditions, physician notification of changes and vital sign parameters.
2. All residents were reviewed for irregularities in condition or vital signs.
3. The incident was reviewed was reviewed by the facility's Quality Assurance and Performance Improvement team.

The deficiency remained at a scope and severity of a "D" after implementation of the corrective actions.