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	175500	A. BUILDING _____ B. WING _____	02/16/2023

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

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations KS00177744, KS00177749, and KS 00177314. This 2567 was electronically sent to the facility on 02/21/23.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

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

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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by:
The facility reported a census of 24 residents with 12 sampled. Based on interview and record review, the facility failed to review and revise the care plans for one Resident (R)17, regarding new interventions to prevent falls.

Findings included:

- Review of R17's diagnoses from the "Electronic Health Record" (EHR) documented repeated falls, weakness, amnesia (a dramatic form of memory loss) and Alzheimer's disease (a progressive dementia - loss of cognitive function such as thinking, remembering and reasoning).

Review of R17's annual "Minimum Data Set" (MDS), dated 01/02/23, documented a brief interview for mental status (BIMS) of 12, indicating moderately impaired cognition. R17 required extensive assistance of two or more staff with transfers.

Review of the Falls Care Area Assessment (CAA) dated 01/02/23, revealed that the resident was at increased risk for falls and injury due to impaired cognition, pain and numbness/weakness to all extremities.

The care plan, dated, 02/11/22 revealed:

A non-injury fall on 02/11/22, with the interventions for staff to remind the resident to use her call light and for staff to pick up dropped items from the floor.

A non-injury fall on 04/02/22, with the intervention for staff to reeducate the resident to use a pendant to call for assistance.

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A non-injury fall on 04/29/22, with the intervention to place a floor mat next to the bed when the resident is in bed, to prevent rolling out of bed.

A non-injury fall on 06/03/22, with the intervention for staff to assess for a concave mattress.

A fall with minor injury on 07/06/22, with the intervention for staff to place a pressure monitor under the mat next to bed, and staff should apply non-skid socks.

A non-injury, unwitnessed fall on 11/20/22, in the chapel bathroom, with intervention for staff to assist the resident to the bathroom every two hours and as needed.

However, the facility lacked interventions for the non-injury fall on 12/08/22. Furthermore, the facility lacked interventions for a repeated fall with injury on 12/18/22.

The Physician's orders lacked documentation of orders specific for fall prevention.

Review of the resident's "assessments" revealed fall risk screenings, dated:

On 10/20/22, with result of 65, indicating high risk for falling.

On 12/18/22, with result of 75, indicating high risk for falling.

On 12/27/22, with result of 75, indicating high risk for falling.

On 01/02/23, with result of 65, indicating high risk

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for falling.

On 02/16/23 at 09:30 AM, Certified Nurse Aide (CNA) N stated that R17 required a personal body alarm for her recliner and her wheelchair, but the resident learned how to disable the audible alarm alerts. Staff should attempt to keep the resident engaged in the common areas as much as possible so all staff can observe the resident, to prevent falls.

On 02/16/23 at 10:06 AM, Licensed Nurse (LN) I reported R17 frequently forgot her limitations and she lacked the cognition to comprehend her limitations. Staff were to place a pressure sensor alarm on R17's recliner and wheelchair, along with a floor mat beside her bed for fall prevention. After a resident's fall, a licensed nurse on duty should implement an immediate intervention until the Interdisciplinary Team (IDT) would meet and develop a permanent intervention for the resident's care plan.

On 02/16/23 at 10:13 AM, Administrative Nurse D reported she expected the licensed nurse on duty at the time of a fall was to implement an immediate intervention until the IDT could meet to create a permanent intervention and update the resident's care plan to prevent further falls. IDT meets at least once per week.

On 02/16/23 at 11:14 AM, Administrative Nurse D confirmed the lack of new interventions on the care plan after the falls on 12/08/22 and 12/18/22.

The 01/23/17 facility's policy for "Fall Prevention Protocol" documented that the IDT would develop a plan for services and other interventions to reduce the elder's risk for falls.

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F 657	Continued From page 4 The facility failed to review and revise this resident's care plan related to falls.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility census totaled 24 residents with 12 in the sample that included four residents for accident hazards. Based on observation, interview, and record review, the facility failed to ensure the fall prevention interventions were implemented to prevent further falls for Resident (R) 28, R12, and R17. The staff left R28 in the dining room without a chair alarm in place, which resulted in a fall with a fracture of her right wrist and her right hip. The facility also failed to replace faulty equipment to prevent a possible fall for R12. Findings included: - R28's diagnoses from the "Electronic Health Record" (EHR) documented anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion), and major depressive disorder (major mood disorder).	F 689		

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The 09/26/22 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of zero, indicating severe cognitive impairment. R28 had no falls since the prior assessment.

The 12/27/22 "Quarterly MDS" documented a staff interview indicating R28 had severe cognitive impairment. The MDS further noted R28 had two or more non-injury falls since the prior assessment.

The 12/27/22 "Care Plan" documented R28 was at risk for injuries related to multiple falls. R28 had an intervention from previous falls for staff to ensure her pressure alarm was in place and working. The staff were to check on R28, frequently.

Review of the "Fall Investigations and Nurse Notes" dated 01/05/23, documented R28 fell, with fractures to her right hip and her right wrist. On 01/05/23, R28 was in the dining room following a meal and staff left her unattended and without her pressure alarm in place, for the meal, from 01:10 PM until her fall at 01:15 PM. R28 noted to have been up and ambulated around her table for three minutes before she fell. The interventions of the pressure alarm and frequent supervision were not observed. Staff notified Emergency Medical Services (EMS, a system that responds to emergencies in need of medical care) and R28 transported to the emergency room for further evaluation and treatment.

Review of the "Witness Statement" dated 01/05/23, revealed Certified Medication Aide (CMA) R documented R28 was in the dining room

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following lunch, when she stood and rearranged the dirty dishes on the table. R28 stood at the table for about a minute before she stumbled and fell onto her right hip, as seen on the video camera. R28 fell when she was left unsupervised in the dining room, after eating, and without her chair alarm.

Review of the "Witness Statement" dated 01/05/23, revealed Administrative Nurse E documented she entered the dining room from the kitchen, advised a Certified Nurse Aide (CNA) to get the charge nurse, the lift, and the vital sign machine. R28 was on the floor in a sitting position, next to her dining room chair. R28's right leg had external rotation and seemed shorter than her left leg. The staff notified 911(emergency call number). R28 fell because she was left alone in the dining room without her alarm, and she tried to stand and fell.

Review of the "Witness Statement" dated 01/05/23, revealed CNA N documented she was down the hall making beds when staff came and told her R28 fell. CNA N went to the dining room and saw R28 sitting on the floor on her bottom. CNA N documented the last time she saw R28 was on 01/05/23 at 12:52 PM. CNA N documented R28 fell because she got up and lost her balance.

Review of the "Witness Statement" dated 01/05/23, revealed CNA O documented a coworker told her R28 was sent to the hospital. The last time CNA O saw R28 was when she was being assisted down to the dining room. CNA O documented she was in another resident's room at the time of the fall. In CNA O's opinion, R28 fell because she did not have her alarm that she was

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supposed to, and she was left alone in the dining room for too long.

Review of the "Witness Statement" dated 01/05/23, Licensed Nurse (LN) I documented on the day of the fall R28 did not have her alarm in place. When she entered the dining room, R28's right leg was noted with visible shortness and gross external rotation, also her right wrist was deformed, and she was guarding and holding it. The staff called 911, with EMS arriving, vital signs listed, local hospital notified of transport for x-rays and further treatment as needed. The staff notified family and administration of the incident.

Review of the "Witness Statement" dated 01/05/23, revealed CNA P documented R28 was in the dining room eating. CNA P left and was coming back to walk R28 to the family room but before she got back, a staff member found R28 on the floor. R28 was cognitively impaired and attempted to clean the table.

Review of the "Witness Statement" dated 01/05/23, CNA Q documented she found R28 sitting on the floor with CNA P. CNA Q heard on the communication device that they needed a lift, the nurse, and vital sign machine. CNA Q went to get the lift. CNA Q noted R28 fell because she did not have her alarm on, and no one was around to watch her.

Review of "Nurse Note" dated 01/06/23, documented R28 transferred from one hospital to another hospital for surgical repair due to a fractured right wrist and a fractured right hip.

On 02/15/23 at 09:29 AM, Administrative Nurse E reported when she walked out of the kitchen, she

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saw R28 on the floor with her legs out in front of her. Administrative Nurse E reported she observed R28's right wrist was deformed, and her right leg was rotated and appeared shorter than the other leg. She instructed the nurse to call for the EMS for transport while Administrative Nurse E sat with R28.

On 02/15/23 at 09:36 AM, Certified Nurse Aide (CNA) N reported that she was working with an agency staff, who CNA N instructed to watch the dining room, while CNA N went down the hall to make beds. When CNA N returned, everyone was in the dining room because R28 fell.

On 02/16/23 at 08:08 AM Licensed Nurse (LN) I reported on the day of the fall, she was called by staff to the dining room, multiple staff were in and out of the dining room and saw R28. R28 did not have her alarm in place. When she entered the dining room, she knew immediately that R28's hip was not positioned correctly, and she called EMS to transport R28.

On 02/16/23 at 11:06 AM, Administrative Nurse D revealed she expected staff to implement a new intervention following a fall and for staff to follow those interventions. She confirmed that for R28's 01/05/23 fall, the interventions had not been followed.

The facilities 07/12/18 "High Fall Risk Protocol" policy documented staff were to provide each resident with adequate supervision and assistive devices to prevent accidents.

The facility failed to provide adequate supervision and assistance devices to prevent accidents, when R28 fell on 01/05/23 that resulted in a right

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wrist and right hip fracture.
- Observation on 02/14/23 at 09:12 AM revealed Licensed Nurse (LN) G, Certified Medication Aide (CMA) M and Certified Nursing Assistant (CNA) N in the resident's room to provide R 12 morning cares.. CMA M raised the head of the bed and CNA N assisted her to pivot transfer from the bed. The resident's brief was wet and removed and staff sat the resident on the bedside commode. LN G held the back of the commode. Observation of the commode revealed the leg to the back rest of the commode. LN G held the back so it did not wobble or collapse while the resident used it. The back bar of the commode also had an area of rust approximately 4 inches long across the bar.

On 02/14/23 at 09:15 AM, LN G stated she noticed commode lacked a wingnut the day before. LN G stated she reported the broken commode to Maintenance Staff U. LN G was unaware how long it had been broken.

On 02/15/23 at 10:00 AM, Maintenance Staff U reported no one notified him of the condition of the commode.

On 02/15/23 at 10:40 AM, Maintenance Staff U reported there was a commode with rusted legs and without a wingnut by the back door and he "threw it out".

On 02/16/23 at 10:50 AM, Administrative Nurse D reported staff should have removed the commode once staff determined the wingnut was not on.

The facility lacked a policy for guidance of broken equipment.

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F 689	Continued From page 10 The facility failed to remove unsafe equipment (bedside commode) to prevent a possible injury to R 12 when staff used a rusted commode that lacked a securing/ bracing wingnut.	F 689		