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 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP LODGE HEALTH AND REHABILITATION CENTER	815 N INDEPENDENCE AVENUE 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 results of abbreviated survey for complaint investigation KS00177669. The 2567 was sent electronically on 03/01/23. The 2567 was revised on 03/14/23.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/01/2023

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 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: The facility identified a census of 64 residents with three reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to protect Resident (R)1 from having his personal privacy violated when on 01/23/23 at approximately 12:23 PM, Licensed Nurse (LN) G saw R1 walking down the hallway with without pants on and a blanket at his waist and took her phone out, turned the camera to face R1, and pressed the take photo button, the phone camera flashed, and LN G turned around and laughed. This deficient practice placed R1 at risk for his privacy to be disrupted and placed R1 at risk for degradation and embarrassment. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had the diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), abnormalities of gait and mobility, and disorientation (a mental state marked by confusion about time, place, or who one is). The "Quarterly Minimum Data Set (MDS)," dated 11/04/22, documented R1 could not complete the Brief Interview for Mental Status (BIMS) exam, R1 had short and long termshort- and long-term memory problems, and was moderately impaired in making decisions regarding tasks of daily life.	F 583	Past noncompliance: no plan of correction required.	

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The MDS documented R1 had physical behavioral symptoms directed towards others one to three days out of the lookback period and wandered daily. The MDS further documented R1 required supervision with one staff assistance for transfer, ambulation,andambulation, and locomotion on and off the unit. R1 required limited to extensive assistance by one staff for dressing, toileting, personal hygiene, and bathing.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 08/04/22, documented R1 had short and long termshort- and long-term memory loss, and required assistance and supervision with his activities of daily living (ADL's).

The "Communication CAA," dated 08/04/22, documented R1 had a cognitive communication deficit as R1 was only understood sometimes and only understood others sometimes placing R1 at risk for missed messages, isolation, and depression.

The "Behavior Care Plan," dated 09/08/21, documented R1 had poor impulse control and instructed staff to provide opportunities for positive interaction and attention, to intervene as necessary to protect the rights and safety of others, approachothers, approach and speak to R1 in a calm manner, divert R1's attention, and remove R1 from situations and take him to an alternate location as needed.

The "Witness Statement," dated 01/23/23, documented at approximately 12:53 PM, R2 had called the office and told the Business Office Manager GG that there was a naked man that walked by R2's door. The business office called

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the south nurse's desk to inform them of the situation. The Business Office Manager GG looked out the business office door and saw LN G pull out her phone and aim it towards R1 as LN G walked towards R1. The Business Office Manager GG ran back to the office to look at the camera footage and saw LN G take a picture of R1. The Business Office Manager GG notified Administrative Nurse D about what she saw and showed Administrative Nurse D the footage.

The "Witness Statement," dated 01/23/23, documented Certified Nurse Aide (CNA) M saw R1 walking back to his room with a blanket covering his front area. CNA was walking towards R1 to escort him to his room when she saw LN G pull out her phone and appeared to take a picture of R1. CNA M documented she continued to walk to R1 and got him into the threshold of his room and R1 had no brief or pants on.

The first "Witness Statement," dated 01/23/23, LN G documented as she walked down the fall she felt her phone vibrate in her pocket and she pulled it out of her pocket and saw that it was a Snapchat. LN G documented she pulled the Snapchat app open to reply, snapped a blurry front facing picture of herself only, and sent it.

The second "Witness Statement," dated 02/23/23, LN G documented she was walking west on the south hall when she saw R1 walking towards her. LN G documented she saw R1 dressed in a t-shirt, had a blanket wrapped around his lower body, and shoes. LN G documented she took out her phone to take a picture of R1 to send to leadership because it was her understanding staff were allowed to take pictures of residents who have consented to have

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their pictures posted on the facility's social media site. LN G documented as she got closer to R1 she realized R1 was unkempt, so it would not be an appropriate time for a photo and put her phone away.

The "Facility Incident Report," dated 01/26/23, documented Administrative Staff A was notified of the incident by phone when he was out of the facility. After returning to the facility, Business Office Manager GG informed Administrative Staff A of R2 calling her and informing her of R1 walking down the hall naked, south nurse's desk was notified, and when the Business Office Manager GG looked out her door down the hall she saw LN G take a picture of R1 with her phone. Business Office Manager GG went back and looked at the camera footage, saw a picture being taken and notified Administrative Nurse D. Administrative Staff A reviewed the footage and Administrative Staff D obtained witness statements from LN G and suspended her pending the outcome of the investigation. Administrative Nurse D ensured there were no photos on the phone of R1 before LN G left the facility. Administrative Staff A reviewed the camera footage closely and was able to zoom in and saw LN G remove her phone from her pocket and opened the camera. LN G's face was visible on the phone screen and then LN G switched the camera view to down the hall and LN G zoomed in down the hall and clearly tapped the screen to take a picture which flashed, and then LN G turned around and laughed. LN G was terminated as a result of the investigation.

On 02/16/23 at approximately 11:00 AM, R1 was observed wandering the halls and into the office area. Staff were attempting to redirect R1 back to

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his room. R1 appeared to have no cognition of what staff were saying to him.

On 02/16/23 at 09:30 AM, Administrative Staff A, stated that when he reviewed the camera footage, the camera was pointed right over LN G's shoulder. Administrative Staff A stated he could clearly see LN G open the Snapchat app and the camera of her phone showed her in the phone screen. Administrative Staff A stated then he clearly saw LN G switch the view of the camera down the hall to R1 and tap her screen twice. Administrative Staff A stated that LN G gave two different witness statements which proved she lied about the situation and had clearly been educated regarding the phone use policy, picture taking policy, and social media policy. Administrative Staff A stated that staff were to only use their phones on their breaks and not around residents and only staff that have written authorization by the Administrative Staff A have permission to take photos of residents.

On 02/16/23 at 11:10 AM, R2 stated that she had seen R1 walking past her room without any pants on and she had called and notified the facility.

The facility's "Resident Photograph Policy," dated 12/01/19, documented taking photographs and/or videos of residents or their personal belongings is a violation of residents' right to privacy and confidentiality. All photographs or videos of residents will only be taken by an employee having written authorization from the administrator. Any employee that takes a photograph or video of any resident that is not authorized will be considered abuse. All staff are required to adhere to this policy and sign a copy for their personnel file indicating they have read

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F 583	Continued From page 6 and understand. The facility's "Personal Cell Phone Policy," dated 12/01/19, documented it is the policy of the facility to provide quality care to the resident without interruption. The facility prohibits employees from using personal cell phone for any reason on the nursing units or the working areas of the facility. This includes calls, texts, instant messages, Facebook, chat or any other use of cell phone. Under no circumstances should employees take pictures, videos, or any other personal representations of any resident, family member, visitor or staff member for the purpose of personal use, social media, or any other reason. This deficient practice placed R1 at risk for his privacy to be disrupted and placed R1 at risk for degradation and embarrassment.	F 583		