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	175348	A. BUILDING _____ B. WING _____	C 05/01/2023

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

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F 000	INITIAL COMMENTS The following citations are the result of abbreviated survey and complaint investigation KS00179774 and KS00179799. The 2567 was sent electronically on 05/15/23.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/15/2023

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 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: The facility identified a census of 62 residents with three residents reviewed for notification of changes. The facility failed to provide notification to Resident (R) 1's representative when R1 was involved in a resident to resident altercation which R1 incurred injury. This placed R1 at risk for delayed treatment and support. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of Wernicke's encephalopathy (a degenerative brain disorder), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).	F 580		

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F 580	Continued From page 2	F 580		

The "Quarterly Minimum Data Set (MDS)," dated 03/01/23, documented R1's Brief Interview for Mental Status was unable to be completed and R1 had short-term and long-term memory problems. The MDS documented R1 required extensive assistance of two staff for all Activities of Daily Living (ADL's) except for eating. The MDS further documented R1 had one to three days during the look back period of verbal aggression and rejection of care.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 02/16/23, documented R1 had a diagnosis of Alzheimer's Disease, an altered mood state, and required extensive assistance with his daily cares.

The "Behavior Care Plan," dated 04/12/23, documented R1 had the potential to be verbally aggressive related to his diagnosis of Wernicke's encephalopathy and directed staff to intervene if R1 became agitated, guide R1 away from the source of distress, engage R1 calmly in conversation, and if R1's response was aggressive, walk away calmly and approach R1 at a later time.

The "Psychosocial Well-Being Care Plan," dated 04/30/23, documented R1 had ineffective coping and did not like to be touched by other residents or people because R1 was physically and emotionally bullied by his peers as a child. Encourage others to respect R1's boundaries.

The "Incident Note," dated 04/24/23 at 11:42 AM, documented R2 walked by R1 while leaving the dining room and R2 touched R1 on the shoulder and asked R1 how he was doing. R1 told R2 not to touch him and cursed at R2. A moment later

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R2 raised his right arm and slapped R1 hard across the right side of his face causing R1's body to shift in his wheelchair. R1 was assessed and his vital signs were obtained. A reddened area was noted to R1's right cheek and he had some pain. A neurological assessment was completed and showed no deficiencies. R1 visited with staff and other residents per his normal routine. An ice pack was provided to R1 which he was able to place to his own face but only tolerated the ice pack for a few minutes. R1 stayed in his wheelchair by the nurse's desk.

The "Witness Statement," dated 04/24/23 at approximately 11:30 AM, documented Certified Nurse's Aide (CNA) M heard R2 yelling and looked to see R2 yelling at R1 to quit using the Lord's name in vain. R1 looked confused and CNA M never heard any profanity being used by R1. CNA M then saw R2 scream and bend down with his body. R2 then stood up and was behind R1 and hit R1 with his right fist. R2 then raised his cane in his left hand. CNA M approached R2 and took R2's arm and turned him away from R1 and yelled for help.

The "Witness Statement," dated 04/24/23, documented Speech Therapist GG was assisting another resident in the dining room with therapies. Speech Therapist GG heard CNA M yelling R2's name and saying "no." Speech Therapist GG saw R2 standing behind R1 yelling at R1. CNA M was running towards R2. R2 raised his right arm and slapped R1 on the right side of his face extremely hard causing R1's body to shift completely to the left side of his wheelchair. R2 was led out of the dining room by multiple staff while R2 continued to yell. Speech Therapist GG did not hear R1 say anything to R2 to provoke

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him. Speech Therapist GG stated the resident she was performing therapy with said she did not feel safe in the dining room.

The "Communication with Family Note," dated 04/24/23 at 02:26 PM, documented R1's durable power of attorney (DPOA) stopped by to visit R1. At this time DPOA was unaware of the incident that had taken place in the dining room. The nurse visited with R1's DPOA about the incident in detail and what interventions were completed after the incident. The nurse apologized to R1's DPOA for not calling her right away as staff were tending to the incident and assessing R1 for any changes in condition, pain, or concerns following being slapped in the face. The DPOA was able to address the reason R1 reacted the way he did when he was touched by R2 as he had been bullied by his peers as a child due to his small stature.

The "Nurse's Note," dated 04/25/23 at 08:13 AM, documented R1 had a small, reddened area to his upper right cheek from the incident the day before. R1 did not recall the incident per his normal mentation.

The "Incident Report," dated 04/26/23, documented R2 walked by R1 when leaving the dining room and placed his hand on R1's shoulder and asked R1 how he was doing. R1 cursed at R2 and told R2 not to touch him. A moment later, R2 raised his right arm and slapped R1 hard across the right side of R1's face and causing R1's body to shift in his wheelchair. R2 was directed back to his room and placed on one on one supervision until the trigger was identified. The triggers for R2 were determined as rejection from others. R2 lacked

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understanding of boundaries and personal space and often greeted others by touching them on the shoulders while approaching them. R1 was assessed and vital signs were obtained. A reddened area to his right cheek with pain was noted. A neurological assessment was completed with no deficiencies noted. R1 visited with staff and other residents. An ice pack was provided to R1 which he can place to his face, but he only tolerated it for a few minutes. R1 stayed in his wheelchair by the nurse's desk for close to an hour visiting with others while the nurse kept visual contact with him. R1 then wanted to go to his room to lay down for a nap and staff took R1 to his room and laid him down. Further evaluation and follow-up was done with R1 and R2 and no obvious signs of concerns regarding the psychosocial well-being was evident at the time. R1 no longer retained memory of the recent events and R2 was aware of his actions and will continue to need monitoring of his behavior. A message was left with R2's geri-psych provider who oversaw R2's psychotropic (used to alter mood or thought) medications to evaluate R2 for further treatment. Corrective actions taken were: R1 and R2 were separated immediately, R2 was placed on one-to-one supervision until trigger was identified, the primary care physicians and DPOA's were notified, care plan for both residents were updated, and R2's geri-psych provider was contacted, and new medication orders were received for R2.

On 05/01/23 at 11:00 AM, observation revealed R1 laid in his bed covered up and turned to the wall. R1 woke up when this surveyor knocked on the door. R1 was confused and was unable to converse with this surveyor. There was no bruising or redness noted to the right side of R1's

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face.

On 05/01/23 at 10:38 AM, R1's DPOA stated that she was upset with the facility because she had to find out about the incident in the dining room when she came to the facility at 02:30 PM on 04/24/23. R1's DPOA stated she went into R1's room and R1 was sleeping in his bed which is not abnormal for him. She stated she touched R1's leg to wake him up and R1 jerked up, covered his head with his hands, and shrank away from her like he was scared of her. She said R1 had the start of a black eye, a red abrasion to the right side of his face, and four finger-imprints on the right side of his face. R1 complained that his head hurt and he did not know if he had dreamt it but he thought someone had hit him. R1's DPOA stated the administrator and the director of nursing told her that if her brother had not been using the Lord's name in vain, then R2 would not have hit him. R1's DPOA stated her brother did not deserve to be hit by R2 regardless if he used the Lord's name in vain or not. R1's DPOA was worried about the close proximity of R1 and R2's room as they are only three doors away and R2 was ambulatory.

On 05/01/23 at 11:10 AM, CNA N stated R1 was not a problem in the dining room. R1 was able to eat independently. CNA N stated R1 occasionally would get verbally aggressive with cares but otherwise he was no problem. CNA stated that R2 had been having more and more outbursts in the dining room and had been throwing plates and glasses in the dining room and at staff. CNA N stated that R2 was not always easily redirectable and could be scary.

On 05/01/23 at 10:30 AM, Administrative Nurse D

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F 580	Continued From page 7 stated that she had not informed R1's representative of the incident right away because she was concerned with making sure the residents were okay and starting the investigation. Administrative Nurse D admitted that R1's representative had come to visit him at the facility and had seen the injuries before the facility had a chance to notify her. The facility's "Notification of Changes Policy," dated 01/01/20, documented the facility would promptly inform the resident, consult the resident's physician and notify consistent with his or her authority the resident's representative when there is a change requiring notification. The facility failed to provide notification to R1's representative when R1 was involved in a resident to resident altercation in which R1 incurred injury. This placed R1 at risk for delayed treatment and support.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		

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involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 62 residents with three residents reviewed for abuse, neglect, and exploitation. The facility failed to provide adequate supervision and failed to implement interventions to prevent an incident of resident to resident abuse from occurring when Resident (R) 2 struck R1 in the face. On 04/24/23 at approximately 12:00 PM, R2 was exiting the dining room and stopped at a table and touched R1 on the shoulder. R2 asked R1 how he was doing. R1 said cursed, and commanded R2 not to touch him. R2 drew his hand back and hit R1 on the right side of the face with enough force to shift R1's body in his wheelchair. R1 and R2 were separated immediately afterwards. Staff escorted R2 back to his room. Staff escorted R1 to his room, assessed for injuries and obtained vital signs. R1 had a reddened area on the right side of his face that was painful; staff applied ice as R1 would allow. The facility did not notify R1's Durable Power of Attorney (DPOA) about the altercation with injury. At approximately 02:30 PM, R1's DPOA came to visit him. R1 was sleeping in bed and R1's DPOA shook his leg to wake him up. When R1 woke up, he placed his hands over his head and shrunk back away from his DPOA in fear. As a result of the resident to resident abuse, R1 had an abrasion on his face, discoloration around his eye and on his face, as well as residual fear evidenced by demonstration of protecting his head and face and recoiling from physical contact from his DPOA.

Findings included:

- R1's Electronic Medical Record (EMR)

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documented diagnoses of Wernicke's encephalopathy (a degenerative brain disorder), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

The "Quarterly Minimum Data Set (MDS)," dated 03/01/23, documented R1's Brief Interview for Mental Status was unable to be completed and R1 had short-term and long-term memory problems. The MDS documented R1 required extensive assistance of two staff for all Activities of Daily Living (ADL's) except for eating. The MDS further documented R1 had one to three days during the look back period of verbal aggression and rejection of care.

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The "Behavior Care Plan," dated 04/12/23, documented R1 had the potential to be verbally aggressive related to his diagnosis of Wernicke's encephalopathy and directed staff to intervene if R1 became agitated, guide R1 away from the source of distress, engage R1 calmly in conversation, and if R1's response was aggressive, walk away calmly and approach R1 at a later time.

The "Psychosocial Well-Being Care Plan," dated 04/30/23, documented R1 had ineffective coping and did not like to be touched by other residents or people because R1 was physically and

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emotionally bullied by his peers as a child. Encourage others to respect R1's boundaries.

The "Incident Note," dated 04/24/23 at 11:42 AM, documented R2 walked by R1 while leaving the dining room and R2 touched R1 on the shoulder and asked R1 how he was doing. R1 told R2 not to touch him and cursed at R2. A moment later R2 raised his right arm and slapped R1 hard across the right side of his face causing R1's body to shift in his wheelchair. R1 was assessed and his vital signs were obtained. A reddened area was noted to R1's right cheek and he had some pain. A neurological assessment was completed and showed no deficiencies. R1 visited with staff and other residents per his normal routine. An ice pack was provided to R1 which he was able to place to his own face but only tolerated the ice pack for a few minutes. R1 stayed in his wheelchair by the nurse's desk.

The "Witness Statement," dated 04/24/23 at approximately 11:30 AM, documented Certified Nurse's Aide (CNA) M heard R2 yelling and looked to see R2 yelling at R1 to quit using the Lord's name in vain. R1 looked confused and CNA M never heard any profanity being used by R1. CNA M then saw R2 scream and bend down with his body. R2 then stood up and was behind R1 and hit R1 with his right fist. R2 then raised his cane in his left hand. CNA M approached R2 and took R2's arm and turned him away from R1 and yelled for help.

The "Witness Statement," dated 04/24/23, documented Speech Therapist GG was assisting another resident in the dining room with therapies. Speech Therapist GG heard CNA M yelling R2's name and saying "no." Speech

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Therapist GG saw R2 standing behind R1 yelling at R1. CNA M was running towards R2. R2 raised his right arm and slapped R1 on the right side of his face extremely hard causing R1's body to shift completely to the left side of his wheelchair. R2 was led out of the dining room by multiple staff while R2 continued to yell. Speech Therapist GG did not hear R1 say anything to R2 to provoke him. Speech Therapist GG stated the resident she was performing therapy with said she did not feel safe in the dining room.

The "Communication with Family Note," dated 04/24/23 at 02:26 PM, documented R1's sister/DPOA stopped by to visit R1. At this time DPOA was unaware of the incident that had taken place in the dining room. The nurse visited with R1's DPOA about the incident in detail and what interventions were completed after the incident. The nurse apologized to R1's DPOA for not calling her right away as staff were tending to the incident and assessing R1 for any changes in condition, pain, or concerns following being slapped in the face. The DPOA was able to address the reason R1 reacted the way he did when he was touched by R2 as he had been bullied by his peers as a child due to his small stature.

The "Nurse's Note," dated 04/25/23 at 08:13 AM, documented R1 had a small, reddened area to his upper right cheek from the incident the day before. R1 did not recall the incident per his normal mentation.

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(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 600	Continued From page 12	F 600		

cursed at R2 and told R2 not to touch him. A moment later, R2 raised his right arm and slapped R1 hard across the right side of R1's face and causing R1's body to shift in his wheelchair. R2 was directed back to his room and placed on one on one supervision until the trigger was identified. The triggers for R2 were determined as rejection from others. R2 lacked understanding of boundaries and personal space and often greeted others by touching them on the shoulders while approaching them. R1 was assessed and vital signs were obtained. A reddened area to his right cheek with pain was noted. A neurological assessment was completed with no deficiencies noted. R1 visited with staff and other residents. An ice pack was provided to R1 which he can place to his face, but he only tolerated it for a few minutes. R1 stayed in his wheelchair by the nurse's desk for close to an hour visiting with others while the nurse kept visual contact with him. R1 then wanted to go to his room to lay down for a nap and staff took R1 to his room and laid him down. Further evaluation and follow-up was done with R1 and R2 and no obvious signs of concerns regarding the psychosocial well-being was evident at the time. R1 no longer retained memory of the recent events and R2 was aware of his actions and will continue to need monitoring of his behavior. A message was left with R2's geri-psych provider who oversaw R2's psychotropic (used to alter mood or thought) medications to evaluate R2 for further treatment. Corrective actions taken were: R1 and R2 were separated immediately, R2 was placed on one-to-one supervision until trigger was identified, the primary care physicians and DPOA's were notified, care plan for both residents were updated, and R2's geri-psych provider was contacted, and new medication

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 05/01/2023

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orders were received for R2.

On 05/01/23 at 11:00 AM, observation revealed R1 laid in his bed covered up and turned to the wall. R1 woke up when this surveyor knocked on the door. R1 was confused and was unable to converse with this surveyor. There was no bruising or redness noted to the right side of R1's face.

On 05/01/23 at 10:38 AM, R1's DPOA stated that she was upset with the facility because she had to find out about the incident in the dining room when she came to the facility at 02:30 PM on 04/24/23. R1's DPOA stated she went into R1's room and R1 was sleeping in his bed which is not abnormal for him. She stated she touched R1's leg to wake him up and R1 jerked up, covered his head with his hands, and shrank away from her like he was scared of her. She said R1 had the start of a black eye, a red abrasion to the right side of his face, and four finger-imprints on the right side of his face. R1 complained that his head hurt and he did not know if he had dreamt it but he thought someone had hit him. R1's DPOA stated the administrator and the director of nursing told her that if her brother had not been using the Lord's name in vain, then R2 would not have hit him. R1's DPOA stated her brother did not deserve to be hit by R2 regardless if he used the Lord's name in vain or not. R1's DPOA was worried about the close proximity of R1 and R2's room as they are only three doors away and R2 was ambulatory.

On 05/01/23 at 11:10 AM, CNA N stated R1 was not a problem in the dining room. R1 was able to eat independently. CNA N stated R1 occasionally would get verbally aggressive with cares but otherwise he was no problem. CNA stated that

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F 600	Continued From page 14	F 600		

R2 had been having more and more outbursts in the dining room and had been throwing plates and glasses in the dining room and at staff. CNA N stated that R2 was not always easily redirectable and could be scary.

On 05/01/23 at 10:30 AM, Administrative Nurse D stated that R2 had become more and more of a problem at the facility with more frequent outbursts. Administrative Nurse D stated R2 refused to take his psychiatric medications because he did not like how the medications made him feel. Administrative Nurse D stated that the facility had tried to find a more appropriate placement for R2 but has not had any success. Administrative Nurse D stated that after this incident she told R2 that he was going to have start taking his medications if he wanted to stay at the facility due to his hallucinations and paranoia.

The facility's "Freedom from Abuse, Neglect, and Exploitation Policy and Procedure," dated 2017, documented it is the facility's policy to provide for the safety and dignity of all its residents by implementing proper procedures for enforcing the residents' rights to be free from abuse, neglect, misappropriation of resident property, and exploitation.

The facility failed to provide a safe, adequate, supervision and interventions to prevent an incident of resident to resident abuse when R2 struck R1 forcefully in the face resulting in discoloration, an abrasion as well as a psychosocial harm as evidenced by physical manifestations of fear.