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 11/20/2023

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 findings of complaint investigation #KS00183988.. The 2567 was sent electronically on 11/21/23.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: The facility had a census of 63 residents. The sample included three residents reviewed for misappropriation and exploitation. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 was free from misappropriation when an employee of the facility used R1's money to make purchases for R1 but did not purchase the items and could not produce receipts for the money spent. This deficient practice placed R1 at risk for ongoing misappropriation and exploitation. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and	F 602		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/21/2023

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.

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 11/20/2023

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 602	Continued From page 1	F 602		

chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Admission Minimum Data Set" (MDS), dated 06/18/23, documented R1 had intact cognition and had no behaviors. The MDS further documented R1 required extensive assistance of one staff for bed mobility, transfers, personal hygiene, and limited assistance of one staff for ambulation, dressing, and toileting.

The "Quarterly MDS," dated 09/18/23, documented R1's cognition was not assessed, and she did not have any behaviors. The MDS further documented R1 required supervision and one staff assistance for bed mobility, transfers, ambulation, dressing, and toileting.

The "Nurse's Note," dated 11/09/23, documented staff visited with R1 regarding her shopping both in the past and in the future and obtained a statement regarding the issues with her current shopping list to find out what was received versus what was outstanding. R1 was informed that in the future, the activities personnel would be the only ones doing resident shopping to help alleviate discrepancies with shopping trips, and R1 understood the discussion.

The facility's "Incident Intake" recorded the incident was reported to the State Agency (SA) on 11/13/23 by Administrative Staff A. The intake documented on 11/09/23 at 02:00 PM, Administrative Nurse D suspected misappropriation of funds for R1. The intake further documented Social Services Designee (SSD) X took money out of R1's trust account,

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 11/20/2023

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 602	Continued From page 2	F 602		

$200.00 on 10/20/23, and $320.00 on 10/26/23, to purchase items for R1 and her partner. The items ranged from a laptop, refrigerator, and cigarettes. R1 was missing two cartons of cigarettes, a battery pack, some shirts with built-in bras, t-shirts with pockets, winter gloves, and a stocking cap. R1 told staff she asked for her cartons of cigarettes and only received a pack or two. R1 further reported to staff that items that were brought into her (by SSD X) were already opened and had no tags on them. The investigation documented R1 did not receive any receipts and neither did the business office. The facility notified the police, and an officer visited the facility. SSD X was unable to produce significant evidence of what was purchased resulting in the termination of SSD X's employment on 11/14/23.

Review of SSD X's background check revealed no concerns were noted.

SSD X's undated written statement documented she purchased cigarettes, clothing, and a cell phone power bank for R1.

On 11/20/23 at 11:50 AM, observation revealed R1 sat in her room. R1 stated she was supposed to get four cartons of cigarettes, various clothing, cell phone batteries, and a longer cell phone cord, but only was given a couple packs of cigarette, a scratched-up laptop table, and a used coat. R1 stated she felt something was not right and kept inquiring when she would get all of the other items; she was told that everything was in SSD X's car and that she would get them to the resident when she had time, but never did. R1 stated SSD X brought in a paper for her to sign but did not explain what the paper was; R1 stated

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 11/20/2023

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 602	Continued From page 3	F 602		

she signed the paper anyway. R1 stated the situation was handled quickly, the police talked with her, and she was reimbursed by the facility. R1 further stated she had never had that happen to her before and was not worried about it happening again; she felt safe in the facility.

On 11/20/23 at 08:38 AM, Administrative Staff A stated he learned about the situation when R1 wanted the cigarettes SSD X was supposed to buy for her as well as other items that she had not received. Administrative Staff A further stated he asked SSD X to produce the receipts for the items that were purchased, and SSD X was only able to provide two receipts. An investigation was started, and SSD X was suspended on 11/09/23. Administrative Staff A stated he notified the police, and SSD X was later terminated on 11/14/23. He said staff were reeducated regarding abuse and neglect.

On 11/20/23 09:57 AM, Administrative Staff B stated SSD X came to her on 10/20/23 and asked to withdraw $200.00 from R1's account to buy items for the resident. Administrative Staff B further stated she told SSD X to make sure she kept the receipts and SSD X came back a few days later and asked to withdraw another $320.00. Administrative Staff B asked SSD X where the receipts were from the last money she had withdrawn from the resident, and SSD X stated she had the receipts and would bring them to Administrative Staff B, but never did. Administrative Staff B stated she told SSD X that she needed the receipts for the purchase but was told that SSD X gave the receipts to R1 and R1 threw them away. Fearing SSD X would get into trouble, Administrative Staff B stated she advised SSD X to write the items, and amount spent, on a

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 11/20/2023

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 602	Continued From page 4	F 602		

piece of paper and take it to the resident and have the resident verify she received her items, so there was some form of record of the purchases. Administrative Staff B stated she gave SSD X more money from the resident's account without the proof of purchase from the previous money spent because she was recently promoted to the position and felt very overwhelmed. Administrative Staff B stated she thought SSD X would produce the receipts.

On 11/20.23 at 11:00 AM, Administrative Nurse D stated she started to get suspicious that something was not right because she heard that R1 was missing cigarettes. When she asked SSD X about it, SSD X said the cigarettes were in her family members car and she would bring them to the facility, but she never did. Administrative Nurse D further stated it was brought to her attention a few days later that SSD X was supposed to buy clothing for R1 and that no receipts were provided to ensure the money was spent on the resident, so she went to Administrative Staff A and told him, and an investigation was started.

On 11/20/23 at 01:30 AM, Activity Staff Z stated when money was withdrawn from a resident's trust account, she signed a withdrawal slip along with the resident, and the receipts were given to the business office. Activity Staff Z further stated now, her assistant and she were the only staff allowed to make purchases for residents; staff would sign the withdrawal slip with the resident. Staff would take the purchase to a charge nurse to verify the item was purchased. Activity Staff Z stated she would then give the receipts to the business office.

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 11/20/2023

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 602	Continued From page 5 The facility's "Freedom from Abuse, Neglect, and Exploitation" policy, dated 11/06/17, documented the facility would ensure that the resident was free from abuse, neglect, misappropriation of resident property, and exploitation and would not employ or otherwise engage individuals who have been found guilty of abuse, neglect, misappropriation of property, or mistreatment by a court of law. The facility failed to ensure R1 was free from misappropriation when an employee of the facility used R1's money to make purchases for R1 but did not purchase the authorized items and could not produce receipts for any money spent. This deficient practice placed R1 at risk for ongoing misappropriation and exploitation.	F 602		