STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N062001	A. BUILDING: _____ B. WING _____	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP LODGE HEALTH AND REHABILITATION CEN	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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility conducted on 06/04/24.	S 000		
S3165 SS=E	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (d) The facility reported a census of 19 residents. The sample included 3 residents. Based on record review and interview for 3 Residents (R)1, R2 and R3, with the potential to affect all residents, Administrator A failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan. Findings included: - R1's "Medical Record" revealed she admitted to the facility on 04/17/23 with diagnoses of chronic obstructive pulmonary disease, diabetes mellitus type II, hypertension, and hypothyroidism. The "Resident Functional Capacity Screen" (FCS) dated 04/15/24 recorded the resident as independent with dressing, toileting, transfers,	S3165		

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

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S3165	Continued From page 1	S3165		

walk/mobility, and eating, required supervision with bathing and was unable to perform management of medications and treatments. R1 was at risk for falls/ unsteadiness, had impaired vision and hearing and used a walker for ambulation.

The "Negotiated Service Agreement" (NSA)/ Health Care Service Plan (HCSP)" dated 04/04/24 recorded staff and resident completed bathing, and medications and treatments were administered by staff. R1 completed dressing, toileting, transfer, walk/mobility and eating independently.

The NSA lacked the name of the current licensed nurse responsible for the implementation of the health care service plan.

- R2's "Medical Record" revealed she admitted to the facility on 01/16/23 with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease, cellulitis, chronic kidney disease and anemia.

The "Resident Functional Capacity Screen" (FCS) dated 01/12/24 recorded the resident as independent with bathing, dressing, toileting, transfers, walk/mobility, eating and management of medications and treatments. R2 used a walker for ambulation.

The "Negotiated Service Agreement" (NSA)/ Health Care Service Plan (HCSP)" dated 03/05/24 recorded resident completed tasks of bathing, dressing, toileting, transfers, walk/mobility, eating and management of medications and treatments independently.

The NSA lacked the name of the current licensed

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S3165	Continued From page 2	S3165		

nurse responsible for the implementation of the health care service plan.

- R3's "Medical Record" revealed she admitted to the facility on 08/12/18 with diagnoses of major depressive disorder, hypertension, diabetes mellitus type II and hyperlipidemia.

The "Resident Functional Capacity Screen" (FCS) dated 08/27/23 recorded the resident as independent with dressing, toileting, transfers, walk/mobility, and eating, required physical assistance with bathing and was unable to perform management of medications and treatments. R1 was at risk for falls/ unsteadiness, had impaired vision and used a walker for ambulation.

The "Negotiated Service Agreement" (NSA)/ Health Care Service Plan (HCSP)" dated 04/03/24 recorded staff assisted with bathing and administered medications and treatments. R3 completed dressing, toileting, transfer, walk/mobility and eating independently.

The NSA lacked the name of the current licensed nurse responsible for the implementation of the health care service plan.

Facility failed to provide a policy on Negotiated Service Agreements.

Interview on 06/04/24 at 01:53 PM with Licensed Nurse B confirmed the NSA documents lacked the current licensed nurse responsible for the implementation of the health care service plan on all residents in the facility and further confirmed the licensed nurse responsible listed on the NSA documents was no longer the licensed nurse responsible.

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S3165	Continued From page 3 Administrator A failed to ensure the negotiated service agreement contained the name of the licensed nurse responsible for the implementation and supervision of the health service plan, which had the potential to affect all residents.	S3165		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced	S3248		

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S3248	Continued From page 4 by: KAR 26-41-102 (d) (2) The facility census equaled 19 residents. The sample included 3 residents and record review of 5 newly hired employees. Based on interview and personnel record review for 2 of 5 staff sampled, Administrator A failed to obtain evidence of supporting documentation for criminal background checks when the background checks were not conducted through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d). Findings included: - On 06/04/24, personnel record review for staff revealed the following: Review of Dietary Staff E's employee record revealed they hired onto the facility on 05/12/23. Record lacked evidence of criminal background check completed through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d). Review of Dietary Staff F's employee record revealed they hired onto the facility on 05/12/23. Record lacked evidence of criminal background check completed through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d). Interview on 06/05/24 with Administrator A and Licensed Nurse B stated they were unable to locate the criminal background checks completed through the Kansas Department for Aging and Disability Services according to K.S.A 39-970 (d) on newly hired Dietary Staff E and F and would look for the documentation.	S3248		

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S3248	Continued From page 5 Facility's "Criminal Background Checks" policy (no date) recorded, "Criminal background checks will be performed on new employees through the KBI via the Kansas Department of Health and Environment (KDHE) within 30 days of employment." For all residents, Administrator A failed to obtain evidence of supporting documentation for criminal background checks of facility staff, pursuant to K.S.A. 39-970 and amendments thereto.	S3248		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by:	S3280		

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S3280	Continued From page 6 KAR 26-41-104 (d) (3) The census equaled 19 residents. The sample included 3 residents and review of 5 newly hired employee records. Based on record review and interview, Administrator A failed to ensure disaster and emergency preparedness by ensuring the performance of quarterly review of the facility's entire "Emergency Management Plan" with staff and residents. Findings included: - Review of the facility "Emergency Management Plan" revealed the plan contained procedures to manage potential emergencies and disasters including fire, flood, severe weather, tornado, explosion, natural gas leak, lack of electrical, or water service, and missing residents. Review on 06/04/24 of the facility's quarterly reviews of the emergency management plan revealed the following reviews completed with staff: 04/15/23 04/01/24 The facility failed to provide documentation regarding emergency management plan reviews with staff for the first, third and fourth quarters of 2023 and the first quarter of 2024. The facility failed to provide documentation regarding emergency management plan reviews with residents for the first, second, third and fourth quarters of 2023 and the first quarter of 2024. Interview on 06/04/24 at 11:08 PM with	S3280		

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S3280	Continued From page 7 Administrator A confirmed no reviews completed with staff for the first, third and fourth quarters of 2023 and the first quarter of 2024 and further confirmed no reviews were completed with residents. Facility's "Emergency Preparedness Plan" policy (no date) recorded, "10. Training will be provided on the contents of the plan, and drills and exercises will be conducted in order to test the plan." Policy failed to identify how often the plan would be reviewed with residents and staff. Administrator A failed to ensure disaster and emergency preparedness by the failure to ensure the performance of quarterly reviews of the facility's entire emergency plan with staff and residents.	S3280		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (e) The census equaled 19 residents. The sample included 3 residents. Based on interview and observation for all residents receiving meal services, Administrator A failed to ensure the facility staff stored all food under safe and	S3299		

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S3299	Continued From page 8 sanitary conditions. Findings included: - Observation during the initial tour on 06/04/24 at 10:06 AM revealed a kitchen. Observation of the refrigerator revealed condiments in squeeze bottles, which were not labeled or dated. Licensed Nurse B identified the squeeze bottles as the following: soy sauce, ketchup, Dorothy Lynch dressing and barbeque sauce. Observation of the refrigerator revealed a second squeeze bottle, which Licensed Nurse B identified as Dorothy Lynch dressing. The bottle was not labeled or dated and did not have a lid on it. Observation of the freezer revealed the following foods, which were not sealed, labeled, or dated: one plastic bag containing unidentified meat, one plastic bag containing chicken patties, one brown paper bag containing potatoes, one plastic bag containing breadsticks, one plastic bag containing shredded cheese, one plastic bag containing biscuits and one plastic bag containing cookies. Interview on 06/04/24 at 10:06 AM with Licensed Nurse B confirmed the above listed food items were not sealed, labeled, and dated correctly. Facility's "Food Preparation and Storage Policy" (no date) recorded, "All food must be kept in closed containers, at appropriate temperatures." Policy failed to identify procedure for dating and labeling food. For all residents receiving meal services, Administrator A failed to ensure the facility staff	S3299		

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S3299	Continued From page 9 stored all food under safe and sanitary conditions.	S3299		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: K.A.R 26-41-207 (c) The census totaled 19 residents. The sample included 3 residents and review of 5 newly hired employees. Based on record review and interview for 3 of 3 sampled residents (R)1, R2 and R3 and 5 sampled staff (Licensed Nurse (LN) B, LN C, Dietary Staff D, Dietary Staff E and Dietary Staff F, the facility failed to ensure compliance with the State Agency's tuberculosis (TB) guidelines. Findings included: - R1's "Health Record" revealed she admitted to the facility on 04/17/23 and the record lacked	S3310		

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S3310	Continued From page 10	S3310		

completion of a TB questionnaire upon admission and annually for 2024.

R2's "Health Record" revealed she admitted to the facility on 01/16/23 and the record lacked completion of a TB questionnaire upon admission and annually for 2024.

R3's "Health Record" revealed she admitted to the facility on 08/12/18 and the record lacked completion of an annual TB questionnaire for 2023.

- Review of LN B's employee record revealed they hired onto the facility on 09/22/23. LN B's first step of TB testing was completed on 02/13/24, approximately 5 months after being hired by the facility. LN B's TB questionnaire was completed on 10/15/23, approximately 3 weeks after being hired by the facility.

Review of LN C's employee record revealed they hired onto the facility on 01/24/23. LN C's record revealed a TB test completed on 08/10/22, 06/26/23 and 07/10/23. LN C's TB questionnaire was completed on 05/09/23, approximately 15 weeks after being hired by the facility.

Review of Dietary Staff D's employee record revealed they hired onto the facility on 11/06/23. Dietary Staff D's record lacked evidence of TB testing and a TB questionnaire upon hire.

Review of Dietary Staff E's employee record revealed they hired onto the facility on 05/12/23. Dietary Staff E's record lacked evidence of TB testing and a TB questionnaire upon hire.

Review of Dietary Staff F's employee record revealed they hired onto the facility on 05/12/23.

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S3310	Continued From page 11 Dietary Staff F's record lacked evidence of TB testing and a TB questionnaire upon hire. Interview on 06/04/24 at 01:49 PM with Administrator A and LN B confirmed TB questionnaires not completed upon hire for LN B and LN C and further confirmed TB testing and a TB questionnaire was not completed upon hire for Dietary Staff D, Dietary Staff E and Dietary Staff F. Facility's "TB Test Policy" dated 12/01/04 recorded, "1. All residents and employees will be given the 2 step Mantoux T.B. Test on admission per state requirement. 2. All new employees will receive a two step Mantoux T.B. Test beginning with employment." Policy failed to identify procedures for obtaining TB questionnaires for residents and staff. The facility failed to ensure compliance with the State Agency's tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105, which had the potential to affect all residents.	S3310		