STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265597	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP AT BLUE RIVER, THE	10425 CHESTNUT DR KANSAS CITY, MO 64137

(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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain a physician order for self-administration of medication at bedside and failed to evaluate and document the ability to self-administer medication for one sample resident (Resident #3) out of 12 sampled residents. The facility census was 137 residents. Review of the facility's policy titled "Resident Self-Admin Meds Clinically Appropriate" dated August 2020 showed: -If a resident desired to self-administer medications, an assessment was conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out the responsibility during the care planning process. -For residents who self-administer, the interdisciplinary team verified the resident's ability to self-administer medications by means of skill assessment conducted on a monthly basis or when there was a significant change in condition. -The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage were recorded in the resident's medical record on the care plan for each medication authorized for self-administration, the label would contain a notation that it may be self-administered. -If the resident demonstrated the ability to safely self-administer medications, a further	F 554		2-2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2-10-2025

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 554	Continued From page 1	F 554		

assessment of the safety of bedside medication storage would be conducted.
-When the interdisciplinary team determined that the bedside or in-room storage of medications would be a safety risk to other residents, the medications of the residents permitted to self-administer would be stored in the central medication cart or medication room.

1. Review of Resident #3's face sheet showed he/she readmitted to the facility on 12/23/24 with the following diagnoses:
-Insomnia (persistent problems falling and staying asleep) Due to Other Mental Disorder.
-Scoliosis (abnormal lateral curvature of the spine).
-Spondylosis (a general term for age-related wear and tear of the spinal discs).

Review of the resident's Prospective Payment System (PPS) five-day Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) assessment dated 12/24/24 showed the resident was cognitively intact.

Review of the resident's care plan dated 12/24/24 showed:
-No focus or intervention related to self-administration of medications.
-He/She received pain medications.

Review of the resident's Physician Order Sheet dated January 2025 showed:
-No order for the resident to be able to self-administer any medication.
-An order for Melatonin (a sleep supplement) tablet three milligrams (mg), give two tablets by mouth at bedtime for Insomnia.

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F 554	Continued From page 2	F 554		

-An order for Tylenol (Acetaminophen- used to treat pain and reduce fevers) tablet 325 mg, give two tablets by mouth every six hours as needed for pain.

Observation on 1/9/25 at 10:56 A.M. of the resident's room showed:
-A bottle of Melatonin 10 mg.
-An empty bottle of Extra Strength Tylenol 500 mg.
-Both bottles were in the bottom drawer of his/her nightstand.

During an interview on 1/9/25 at 10:56 A.M. the resident said:
-He/She thought a staff person came around and had him/her sign something related to his/her medications, but he/she was unsure of what it was.
-The staff were not aware that he/she had medication stored in his/her room.
-His/Her family gave him/her the medication.
-He/She had taken the last of his/her Tylenol that day.

During an interview on 1/9/25 at 12:27 P.M. Certified Medication Technician (CMT) A said:
-He/She had previously found medications at the resident's bedside.
-The staff had found pill bottles in his/her room previously and removed them.
-The resident did not have an order to self-administer medications.
-He/She did not think that the resident had any medications in his/her room at that point in time.
-The resident had an order for Tylenol 325 mg, take two for a total of 650 mg, as needed for pain.
-He/She was unsure about the resident's dosage of Melatonin.

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F 554	Continued From page 3	F 554		

-He/She had never seen the resident's family member before, so he/she was unsure if the he/she had brought medications to the resident in the past.
-The resident should not have any medications at his/her bedside or stored in his/her room.
-An assessment needed to be completed by the nurses and an order needed to be obtained in order for residents to keep medications at their bedside.
-He/She did not think the resident would qualify as a candidate to have medications stored in his/her room.

During an interview on 1/9/25 at 12:50 P.M. the Director of Nursing (DON) said:
-The resident did not have a current order for the resident to keep any medications at bedside.
-The resident did not have a current assessment for the resident to keep medication at bedside.
-The resident should not have any medication stored in his/her room.
-He/She was unaware that the resident had medications in his/her room until he/she had only just been told about them.

During an interview on 1/9/25 at 1:33 P.M. the resident said:
-He/She had taken the Tylenol that was in his/her room at least two times a day for the pain in his/her back.
-He/She had taken two tablets of his/her Melatonin and what the facility gave him/her equaling 26 mg of Melatonin at night, every night since she has had the bottle of the Melatonin in his/her room.
-He/She had been given the bottles of medication after he/she had gotten back from the hospital on 12/23/24.

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F 554	Continued From page 4	F 554		

During an interview on 1/9/25 at 1:38 A.M. Licensed Practical Nurse (LPN) A said:
-The resident was not allowed to keep any medication at his/her bedside.
-The resident would need to have a doctor's order to have medication stored at his/her bedside.
-He/She was unsure if the resident had any medication stored in his/her room at that point in time.
-He/She was unaware that medications had been taken out of the resident's room previously.
-He/She was unsure of how the resident could have received the bottles of medication to keep in his/her room.
-He/She was unaware that the resident had been giving himself/herself extra doses of Tylenol and Melatonin.
-The bottles of medication needed to be taken out of the resident's room.

During an interview on 1/9/25 at 1:48 P.M. the DON said:
-Residents who wanted to self-administer any medication needed to have an assessment completed.
-The nurses were responsible for completing the self-administration assessment.
-There is a form in the facility's electronic charting system that nurses can use to complete the assessment.
-Residents were able to ask for an assessment to be completed if they wanted to keep any medications at their bedside.
-He/She was responsible for ensuring the completion of self-administration assessments.
-The resident had not expressed that he/she wanted to have any medications kept at his/her bedside.

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F 554	Continued From page 5 -If the resident had expressed that he/she wanted to keep medications at his/her bedside, then the facility would have informed the physician and completed an assessment. -He/She did not think the resident would be a candidate to keep medications at his/her bedside due to being non-compliant with other policies in the facility. During an interview on 1/10/25 at 12:17 P.M. the Psychiatric Nurse Practitioner (NP) said: -It was not appropriate for the resident to have medication at his/her bedside. -He/She expected the staff to watch the residents take all medication. -No resident should have medications at their bedside unless there is an assessment. -He/She did not believe that the facility let residents keep medications at their bedside. MO00247016	F 554		

Missouri Department of Health and Senior Services

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Refer to F554.	A4055		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dana Dan-Ware | Administrator | 2/10/2025

PLAN OF CORRECTION

Provider Name:	HILLTOP AT BLUE RIVER
Street Address, City, Zip:	10425 CHESTNUT DR. KANSAS CITY, MO 64137
Date of Survey:	01/09/2025
Provider number:	265597

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	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance	
	Resident Self-Admin Meds-Clinically Approp **CFR(s): 483.10(c)(7** §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. **This REQUIREMENT is not met as evidenced by:** Based on observation, interview, and record review, the facility allegedly failed to obtain a physician order for self-administration of medication at bedside and allegedly failed to evaluate and document the ability to self-administer medication for one sample resident (**Resident #3**) out of 12 sampled residents. The facility census was 137 residents. MO00247016 **<u>Corrective Action for Affected Residents:</u>** • **Resident # 3** was assessed by Licensed Nurse and suffered no adverse outcomes due to the alleged deficient practice. Dana Dews-Hann 2-7-25 The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.	

- **Resident # 3** was screened on 1/9/25 utilizing the Medication Self Administration Evaluation in Point Click Care.

- **Resident #3** was found to not have the ability to self-administer medications safely by the evaluation results. Medications were removed from the resident's room.

- **Resident #3** stated that son is the one that is providing with substances. The Administrator and DON called and spoke to resident's son on 1/9/2025 and educated him related to facility policy in regard to OTC medications. was made aware that the residents are not to have meds at bedside unless assessed in an order from the physician is obtained. was also made aware that he could no longer provide marijuana and alcohol to his on the premises. was also made aware that if he is noted bringing alcohol and marijuana on the premises again that he risks being banned from facility property. (See nurses note attachment #1)

- The Resident Council meeting was held by the Admin/DON/Designee to address medications at bedside, to include discussing the need to have a physician's order, an evaluation to determine ability to do so and family not being able to bring in medications to the resident's room.

Identification of other residents having potential to be affected was accomplished by:

- Residents residing in the facility have potential to be affected.

Systemic Changes to Prevent Recurrence:

- Director of Nursing/designee conducted an audit of Resident rooms for medications at bedside.

- Director of Nursing/Designee provided education to facility staff to alert the nurse and/or

IDT/DON/Admin if residents are found to have medications at bedside.

- Staff will inform the DON/designee when a resident requests to self-administer medications.
- If the resident desires to self-administer medications, an assessment is conducted utilizing the Medication Self administration Evaluation in Point Click Care.
- If residents are safe to self-administer, the facility will obtain orders for self-administration and will update the care plan.

Monitoring Performance:

- The DON/Designee will monitor **5** resident rooms for unauthorized medication self-administration 2x week x4 weeks. Weekly x 4 weeks and monthly thereafter.
- Results will be forwarded to the Quality Assessment and Assurance Committee for review and recommendations monthly X 3 months and as needed thereafter.
- DON/Designee will audit five rooms weekly for 4 weeks and monthly thereafter. Findings will be immediately addressed and a summary submitted to QAPI for review and recommendations monthly. (See attached

PLAN OF CORRECTION

Provider Name:	HILLTOP AT BLUE RIVER
Street Address, City, Zip:	10425 CHESTNUT DR. KANSAS CITY, MO 64137
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A4055	**19 CSR 30-85.042(46) Safe/Effective Medication System** There shall be a safe and effective system of medication distribution, administration, control, and use. I/II **This regulation is not met as evidenced by:** Class II **1. See the revised deficiency cited at F554**	2/20/25

Nina Dana-Haas 2-10-25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.