

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 143</p> <p>when leaving the room, she would remove the PPE by the door and put it in the biohazard bag. She stated she did not wash her hands in the room prior to exiting, but would go directly to the women's bathroom in the hall and wash hands.</p> <p>Interview with LPN #3, on 03/20/12 at 2:30 PM, revealed handwashing was done before and after care for Resident #8 in the shared bathroom (with room D 17). She stated the aides also emptied Resident #6's urine (from the urinal) into the toilet. She confirmed, the resident in the other room, Resident #13, was toileted in this bathroom by aides. LPN stated this could be an infection risk for Resident #13.</p> <p>Interview with CNA #10, on 03/20/12 at 3:45 PM, revealed when caring for Resident #6, she would wash her hands in the shared bathroom. In addition, she would empty the resident's urine from the urinary drainage bag into the urinal and empty the urine in the toilet and then rinse the urinal with sink water and empty the remains from the urinal into the toilet. She confirmed she did not disinfect the sink or toilet afterward. CNA #10 also stated the resident in the next room, (Resident #13) did use the toilet and washed his/her hands in the sink. She stated this could be an infection control risk.</p> <p>5. Review of the facility's infection control program related to the tracking and trending of infection surveillance data, and interview with the Director of Nursing (DON)/Infection Control Nurse (ICN), on 03/15/12 at 5:15 PM, revealed the facility tracked infections monthly through reports of residents on antibiotics received from the pharmacy. The DON/ICN stated the lab also sent</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360</b>
--	---

(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 441	<p>Continued From page 144</p> <p>a monthly report of any specimen cultures, if done, to identify the organism. However, she stated she did not really look at the organism for patterns of infection, but by type of infection itself such as urinary tract infections (UTIs), and upper respiratory infections (URIs). Further interview regarding where infections were acquired, revealed she did not track if the infections were acquired in the facility or outside the facility to assist in tracking and trending outbreaks. She stated, if they were on antibiotics they were counted as an infection on their data.</p> <p>Further interview with the DON/ICN, on 03/15/12 at 5:15 PM, and review of the infection control program's surveillance data related to identification and control of infections revealed the facility analyzed infection data monthly and when a trend was identified she took actions to prevent further spread of the infection. Review of the January 2012 and February 2012 infection data revealed the facility had identified a trend of UTI's (total of 10 UTIs) and the action taken was to review correct handwashing, glove changes, and perineal-care with staff. However, further interview with the DON/ICN regarding actions taken to prevent the spread of UTIs, on 03/21/12 at 10:30 AM, revealed she had not preformed the corrective actions listed to prevent the spread of UTIs and did not inservice staff on preventive measures such as proper perineal-care with staff.</p> <p>6. Observation of a skin assessment and dressing change, on 03/14/12 at 1:20 PM, for Resident #3 revealed LPN #2 removed the soiled dressing from the resident's gastric tube site, and discarded the soiled gloves. She then donned</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 145</p> <p>new gloves and cleansed the resident's gastric tube site with a disposable wash cloth and removed the soiled gloves. LPN #2 then donned new gloves and cut a 4 x 4 gauze dressing to make a slit for the gastric tube, placed the dressing directly on the resident's bedside table and applied Double Antibiotic Ointment to the dressing. LPN #2 then placed the dressing over the gastric tube site and could not find the tape to secure the dressing. While waiting for staff to bring the tape into the room, LPN #2 palpated the resident's feet as part of the skin assessment, and then taped the dressing to the resident's gastric tube site.</p> <p>When LPN #2 was questioned by the surveyor, on 03/14/12 at 3:45 PM, related to the need to wash hands after removing a soiled dressing and prior to donning new gloves to cleanse the gastric-tube site, LPN #2 stated there was no drainage on the old dressing, so she did not feel her hands were contaminated. Further interview revealed she did not think it was a problem to place the new dressing directly on the bedside table because the part of the dressing with the ointment was facing up and not touching the table, and that was the side of the dressing which touched the resident's skin. Continued interview verified she did touch the resident's feet while waiting for the tape, but did not feel the need to wash her hands after touching the feet and prior to taping the dressing. She further stated she had not been audited by the administrative nurses on dressing changes.</p> <p>Further observation during the skin assessment for Resident #3, revealed LPN #3 who was assisting LPN #2 with the skin assessment,</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 146</p> <p>touched and palpated the resident's feet, and then removed the resident's soiled attends. She then touched the groin as part of the skin assessment. Further observation, revealed she then removed the resident's shirt with the same soiled gloves. Interview on 03/14/12 at 4:00 PM with LPN #3, revealed she did not feel the need to wash her hands and change gloves after palpating the resident's feet and prior to touching the resident's groin area. However, stated she should have changed her gloves prior to moving to the resident's upper torso and removing the resident's shirt.</p> <p>Observation on 03/14/12 at 1:40 PM of a skin assessment for Resident #1, revealed LPN #3 removed the resident's socks, palpated the feet, and then without washing her hands, palpated the groin/vaginal area. Interview, on 03/14/12 at 4:00 PM, with LPN #3 revealed she should have washed her hands after touching the resident's feet and prior to completing the skin assessment of the groin area. She further stated she did not think she had touched the vagina.</p> <p>Interview, on 03/20/12 at 4:00 PM, with the DON/ICN revealed the nurses should wash their hands after removing a soiled dressing and should also wash their hands after palpating a resident's feet and prior to palpating a resident's groin/vaginal area. She also stated a dressing should not be placed on a bedside table without a barrier under the dressing.</p> <p>Observation during medication pass, on 03/16/12 at 3:15 PM, revealed LPN #1 administered crushed medications in applesauce with a spoon to Resident #7, threw the medication cup in the</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 147.</p> <p>trash and exited the room without washing her hands. She then set up and administered medications to Unsampled Resident A. Interview, on 03/16/12 at 3:20 PM, with LPN #1 verified she had failed to wash her hands between administration of medications to Resident #7 and Unsampled Resident A.</p> <p>7. Review of the medical record revealed the facility admitted Resident #4 on 12/23/11 with diagnoses which included Dementia, and Diastolic Heart Failure. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/30/11, revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making.</p> <p>Review of the Nurse's Notes, dated 01/04/12 at 8:15 (did not designate if AM or PM), revealed staff discovered head lice, treatment was given at 4:30 PM, the bed was washed and fresh linens were applied. Further review of Nurse's Notes dated 01/08/12 at 1:00 AM, revealed while grooming the resident's hair, multiple nits were found behind the ears and at the base of the neck. The Note stated, retreated for lice, bed was stripped and washed. Further review revealed, the laundry was kept separated and washed alone and the resident was kept in her/his room for meals.</p> <p>Review of the facility's infection control programs surveillance data related to identification and control of infections revealed Resident #4's head lice was not noted on the data. Interview, on 03/20/12 at 10:00 AM with DON/ICN, revealed she should have documented the pediculosis on the tracking and trending log for the infection</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB-NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 558 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 148 control data. She further stated no other residents had pediculosis because all resident's heads were checked both times Resident #4's head lice was found.</p> <p>8. Review of the medical record revealed Resident #2 was admitted by the facility on 09/01/01 with diagnoses which included history of Cerebral Vascular Accident, Dysphagia, Alzheimer's Disease, Dementia, Depression, and Flaccid Hemiplegia Affecting Unspecified Side.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/27/12, revealed the facility had assessed the resident as needing total assistance with eating by one staff person. Further review revealed the facility had assessed the resident as having a swallowing disorder which included loss of liquids/solids and holding food.</p> <p>Review of the Physician's orders dated 03/12, revealed the resident was on a pureed diet and may use a syringe for fluids.</p> <p>Observation, on 03/14/12 at 5:30 PM, revealed CNA #4 was holding a ten (10) milliliter syringe and was observed to touch the tip of the syringe with her bare hand prior to putting the syringe into the resident's drink, although the syringe was used to provide fluids orally to the resident.</p> <p>Interview with CNA #4, on 03/15/12 at 4:55 PM, revealed she did not remember touching the tip of the syringe with her hand prior to inserting it into the residents drink. CNA #4 further stated she should not have touched the tip with her hand.</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 569 OWINGSVILLE, KY 40360	
(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 441	<p>Continued From page 149</p> <p>Interview with the DON/ICN, on 03/22/12 at 10:45 AM, revealed the CNA should not have touched the tip of the syringe. She stated that was an infection control issue because staff had contaminated the syringe.</p> <p>9. Review of the facility's Infection Control Policy, titled 'Immunizations Protocol', undated, revealed all residents will receive a TB (Tuberculosis) test upon admission and annually.</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on 08/05/10 with diagnoses which included Coronary Obstructive Pulmonary Disease, and Atrial Fibrillation. Review of the resident's Immunization Record revealed the facility administered a Tuberculin Test (TB) on 08/05/10 and on 08/07/10 results revealed a 0 millimeter (mm) duration, meaning a negative result. Further review of the medical record revealed an annual TB skin test was not administered until 02/07/12, eighteen months later.</p> <p>Interview with LPN #1 and LPN #6, on 03/22/12 at 10:30 AM, revealed the goal of the facility was going to be to administer all resident's TB skin test annually during the month of January. Further interview revealed the current process was the Medical Records (MR) Coordinator had a list and when a resident's annual TB skin test was due the MR Coordinator would give the nurses a list and the nurses would be responsible for administering the TB test as well as document the test was given and results of the test on the resident's Immunization Record located in the resident's chart, as well as on the Medication Administration record.</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 150</p> <p>Interview with the MR Coordinator, on 03/22/12 at 11:20 AM, revealed she kept a list of all residents in the facility on a piece of notebook paper and she would put the due date for each resident next to the residents name. Further interview revealed she would periodically go through the list and when the resident's TB test was due she would write the resident's name and due date on a little piece of paper and hand it to whichever nurse was working that day. Additional interview revealed that nurse would be responsible for documenting on the MAR and the immunization record as to when the TB test was given and read. Observation of the list on the notebook paper, at that time, revealed although Resident # 1's name was on the list, there were no dates to indicate when the resident's test was given or due. The MR Coordinator stated she must have just missed documenting the due date on her paper.</p> <p>10. Review of the facility's "Laundry Services" Policy and Procedure, dated 2007, revealed clean linen was not to come in contact with dirty linen. In the laundry, dirty linen should be moved from the dirtiest to the cleanest areas as it was being processed. Further review revealed linens should be washed using the equipment manufacturer's recommendations for appropriate chemical mix and water temperatures.</p> <p>Observation of the laundry room, on 03/15/12 at 11:30 AM, revealed a dirty linen cart in front of the washer which was across from and in close proximity to the dryer. There was no segregation noted between the clean and dirty laundry areas. Interview at that time with Housekeeper/Laundry</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 151</p> <p>Staff Member #1, revealed the laundry staff loaded the dirty hamper from the shower room into the dirty laundry bin and rolled it into the laundry room. Interview, on 03/15/12 at 11:45 AM, with the Housekeeping/ Laundry Supervisor revealed they had always parked the dirty laundry hamper in front of the washer which was right across from and in close proximity to the dryer because it was a small room and there was no place else to place it.</p> <p>Further interview, on 03/15/12 at 11:45 AM, with the Housekeeping/Laundry Supervisor, revealed the staff did not take washing machine temperatures and she would not know how to test the temperature of the washing machine. She stated maintenance kept a log of wash machine temperatures and took the temperatures monthly.</p> <p>Interview, on 03/15/12 at 12:00 PM, with the Maintenance Director revealed maintenance did not check wash machine temperatures and the only routine maintenance in the laundry room was to clean behind the dryers once a week.</p> <p>Interview, on 03/15/12 at 12:30 PM, with the Executive Director revealed there was no separate room for the dirty laundry bins and the clean basket and clean table did not come in contact with the dirty laundry and linens. She stated she was aware the laundry staff was not taking wash machine temperatures and there was no way to test the temperature of the wash machine. She further stated the reason the facility used the Shurguard product was because they thought it would sanitize in any temperature.</p> <p>Continued Interview, on 03/15/12 at 1:20 PM, with</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 152</p> <p>the Housekeeping/Laundry Supervisor revealed when the automatic dispensers for detergent and sanitizer were installed, she was told by the sales representative that the Shurguard Ultimate Sanitizer sanitized in any water temperature. However, review of the reference sheet for the Shurguard Ultimate Sanitizer which the facility used to sanitize colored clothes and colored linens revealed the temperature must be a minimum of ninety-five (95) degrees Fahrenheit to be effective in killing multiple organisms including Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>Interview with the DON/ICM, on 03/15/12 at 5:15 PM; related to the facility's infection control program in addressing how the facility monitored the transporting, and processing of linens to prevent the spread of infections, revealed she was unaware the facility had not been monitoring water temperatures of the laundry. She stated, the housekeeper should have made sure temperatures were being recorded. She further stated, the laundry staff were to make sure the water was hot enough with the chemicals used to kill organisms, such as multi-drug resistant organisms like Methicillin Resistant Staphylococcus Aureus ((MRSA) an organism resistant to multiple antibiotics) and Vancomycin-resistant Enterococcus ((VRE) an organism resistant to the antibiotic Vancomycin). Continued interview, revealed it would be important for laundry personnel to know what temperatures were required to kill organisms. She stated she did not review infection control procedures with the laundry personnel and it was the housekeepers responsibility to instruct her staff on infection control. Further interview</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 153 revealed she did not know what sanitizer was used in the laundry.</p> <p>Phone interview, on 03/16/12 at 3:00 PM and 03/23/12 at 1:15 PM, with the sales representative confirmed the Shurguard Ultimate Sanitizer required a minimum of ninety-five (95) degrees Fahrenheit for the agent to be effective in killing organisms, and he had informed the Housekeeping/Laundry Supervisor of this when the system was installed in 01/12.</p> <p>11. Review of the facility's policy titled, "Regulated Medical Waste Management" revealed the purpose of the policy was to decrease the potential of exposure to regulated medical waste by appropriate management and disposal. Further review revealed storage shall be in a locked location which affords protection from animals, insects, and weather conditions; and minimizes exposure to the public.</p> <p>Review of the Centers for Disease Control and Prevention (CDC) guidelines, revealed health care facilities are to dispose of medical waste regularly to avoid accumulation. The storage should be inaccessible to pests.</p> <p>Observation of the soiled utility room, on 03/14/12 at 5:00 PM, revealed there were two (2) housekeeping carts in the entrance inside the room which had to be removed prior to entering. An accumulation of seven (7) large boxes of biohazard medical waste was noted in the floor and stacked on top of each other. Behind the boxes were shelves containing chemicals such as Virex Disinfectant, Stride Neutral Cleanser, Provon Hand Wash Soap, Hand Sanitizer,</p>	F 441		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 154</p> <p>Bleach. There were also stacks of gowns and towels which were enclosed in plastic. Mopheads were also stored on the shelf. There was a floor buffer and brooms noted in the floor in front of the biohazard medical waste boxes. There was no segregation of the biohazard medical waste boxes and the cleaning chemicals and equipment.</p> <p>Interview, on 03/14/12 at 5:15 PM, with the DON/ICN, Administrator, and Executive Director, revealed the biohazard pickup for the medical waste was at the facility the prior week, which was 03/07/12; and they were contracted for twelve (12) pick ups a year. Further interview with the Executive Director revealed she had called the company again that day for another pick up; however it could take two (2) to three (3) days for a pickup, once the company was notified.</p> <p>Interview with the Director of Nursing (DON)/Infection Control Nurse (ICN), on 03/15/12 at 5:15 PM, revealed staff removed Personal Protective Equipment after taking care of the residents with MRSA and VRE and put them into biohazard bags located in the residents' rooms. To remove the biohazard bags, staff donned gowns, and gloves and tied up the bags before removing them from the room. The bags were then taken down to the soiled utility room and placed in the biohazard medical waste boxes in the soiled utility room. Further interview, revealed the housekeeping carts blocked the entrance to the soiled utility room and the facility did not have a process in place to keep staff from possibly contaminating the carts to get to the biohazard boxes. She stated, staff washed their hands after they exited the soiled utility room. Regarding the</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360</b>
--	---

(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 441	<p>Continued From page 155</p> <p>observation of seven (7) biohazard boxes observed to be in the room, the DON/ICN stated they had increased the pick up by the biohazard waste company. However, she would consider the number of boxes in the room to be an accumulation of waste. Further interview with the DON/ICN regarding pest control revealed she did not think insects could get into the biohazard boxes.</p> <p>Observation on 03/15/12 at 7:15 PM, revealed there were still seven (7) large boxes labeled biohazard medical waste in the soiled utility room. Further observation revealed the Housekeeping/Laundry Supervisor opened a partially taped biohazard box that was located in the soiled utility room. Two flying insects were observed to be flying around inside the box which contained a closed red biohazard bag. Interview with the Housekeeping/Laundry Supervisor at the time of the observation, revealed the biohazard box contained biohazard medical waste such as gowns, gloves, and masks that had been used by staff caring for residents with infections. Continued observation revealed a flying insect flew out of the box and to the hopper spicket which was in the soiled utility room. Further interview with the Housekeeper/Laundry Supervisor at the time revealed the spicket dispensed water mixed with various cleaning chemicals that housekeeping staff poured into their cleaning buckets. She stated the flying insects had been in the building for a week or a week and a half prior to the survey.</p> <p>Observation, on 03/16/12 at 10:20 AM, of the soiled utility room revealed there was still seven (7) large boxes labeled biohazard medical waste</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 156 and flying insects were noted flying around the room.</p> <p>Observation of the soiled utility room, on 03/17/12 at 3:40 PM, revealed there were three (3) boxes labeled biohazard medical waste. Interview at the time with the Housekeeping/Laundry Supervisor, revealed the company came the day before and removed the previous boxes. She stated the facility told the company they would need to come more often and at least once per week.</p> <p>12. According to the Centers for Disease Control and Prevention (CDC) guidelines, insects can serve as agents for the mechanical transmission of microorganisms, or as active participants in the disease transmission process by serving as a vector.</p> <p>Review of the facility's "Pest Control" Policy, revealed the facility was to have a pest control contract that provides frequent treatment of the environment for pests, which would allow for additional visits when a problem was detected. Further review revealed there was to be emphasis on the pest control program in the kitchen, cafeterias, laundries, and other areas prone to infestation. Monitoring of the environment was to be done by facility's staff and pest control problems were to be reported promptly to the contractor.</p> <p>Observation of the employee break room, on 03/13/12 at 11:00 AM, revealed flying insects around the table and sink areas. Further observation during the survey from 03/13/12 through 03/29/12 revealed the flying insects were still noted in the employee break room.</p>	F 441		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 157</p> <p>Observation, on 03/17/12 at 4:10 PM, in the kitchen revealed flying insects around the prep table in the middle of the kitchen and the flying insects landed on the prep table. Observation, on 03/20/12 at 9:45 AM, revealed flying insects around the large trash can outside of the dish machine area. Interview with the Dietary Manager at that time revealed the flying insects had been in the kitchen for two (2) to three (3) weeks and the pest control exterminator was in the building last week.</p> <p>Observation of the resident dining room on 03/26/12 at 4:30 PM, revealed there was a flying insect flying around the vending machine.</p> <p>Interview, on 03/15/12 at 11:50 AM, with the Maintenance Director revealed the problem with the "gnats" just started and the exterminator came in on a regular basis monthly and was called on 03/14/12 to come to the facility related to the "gnats".</p> <p>Interview, on 03/17/12 at 10:00 AM, with the Executive Director revealed the facility had a pest control contract and was serviced monthly. She stated the facility could also call the company between visits if problems were noted. She further stated the facility became aware of the fruit flies on 03/13/12 which was the first day of the survey and the exterminator was there the same day.</p> <p>Interview, on 03/23/12 at 11:50 AM, with the owner of the pest control company which serviced the facility, revealed the company was first notified of the flying insects which were</p>	F 441		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360</b>
--	---

(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 441	<p>Continued From page 158</p> <p>actually "fruit flies" on 03/13/12 when a service technician was sent to the facility; however, could not find the source of the fruit flies. He further stated he was called by the facility on 03/16/12 related to the fruit flies, and he came to the facility himself. He stated he discovered the source which was the dish machine in the kitchen. Further interview revealed there was water standing on the floor under and behind the dish machine and there was fifteen (15) to twenty (20) fruit flies flying around the dish machine and the trash can which did not have a lid and was in close proximity of the dish machine. He informed the facility of his recommendation to clean the kitchen floor under the dish machine, wash the kitchen walls, and obtain a lid for the trash can. He further stated standing water and food particles were a source for fruit flies. Continued interview, revealed he had recommended an enzyme to be placed down all the drains and in the mop water. He stated, if the source and environment for the fruit flies was eliminated, they would not be able to survive. He further stated, fruit flies was not really a concern for the pest control company, but more of a sanitation problem.</p> <p>Review of the Pest Control Invoice, dated 03/16/12, revealed a service call for fruit flies. The invoice indicated there was an inspection of all bathrooms, laundry room, soiled utility room, and kitchen. Further review of the invoice revealed the dishwasher area in the kitchen had standing water underneath. The recommendations included cleaning and drying out the floor.</p> <p>Further interview, on 03/23/12 at 12:00 PM, with</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 159</p> <p>the Maintenance Director revealed the pest control exterminator came in for their regular monthly visit on 03/13/12 and that was the first time he notified the exterminator of the flying insects. He stated staff had notified him of the fruit flies for the first time on 03/13/12 and he had not noticed them until that date. Continued interview revealed, on 03/16/12, the owner of the pest control company came to the facility and walked around the entire building. The exterminator found water standing in the kitchen floor under the dish machine and found moisture behind the rubber baseboard around the wall near the dish machine. He stated he was unsure where the water was coming from but could not find a leak with the dish machine. Further interview verified the trash can in the kitchen near the dish machine had no lid, and a lid was bought to fit the trash can. Continued interview, revealed the owner of the pest control company had recommended an enzyme to be put down all the drains in the building and he had done that on 03/18/12 and had since noted an improvement with the fruit flies.</p> <p>Interview, on 03/23/12 at 3:50 PM, with Certified Nursing Assistant (CNA) #11 revealed the flying insects had been a problem for months and she had seen them in the employee breakroom, resident rooms, and the dining room.</p> <p>Interview, on 03/23/12 at 4:00 PM, with the Office Manager revealed she had noticed the flying insects in the building about a month before the survey started.</p> <p>Interview, on 03/23/12 at 4:00 PM, with CNA #5 revealed she had noticed the flying insects in the</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 160 employee break room for at least a couple of months.</p> <p>Interview, on 03/23/12 at 4:02 PM, with Dietary Aide #1 revealed she had noticed the flying insects in the kitchen, and dining room for the past couple of months.</p> <p>Interview, on 03/23/12 at 4:04 PM, with Dietary Cook #2 revealed she had noticed the flying insects everywhere including the kitchen, dining room and resident rooms for at least two (2) to three (3) months.</p> <p>13. Observation on environmental tour, on 03/13/12 at 10:45 AM until 11:00 AM, revealed the hall storage room had two (2) packages of attends directly on the floor. Resident semi-private bathroom D17 had two (2) urinals which were undated and unlabeled hanging on the trash can and a wash pan was noted on the bathroom floor. Observation, on 03/13/12 at 12:30 PM, revealed an unlabeled emesis basin on the back of the toilet in resident bathroom D33: Observation, on 03/14/12 at 4:30 PM, revealed resident semi-private bathroom room D11 had a toothbrush which was unlabeled on the back of the toilet. Interview, on 03/23/12 at 4:30 PM, with the DON/ICN revealed supplies such as attends should not be directly on the floor. Further interview revealed urinals should be labeled and not be left in semi-private bathrooms, wash pans and emesis basins should be labeled and should not be in the floor or in the semi-private bathrooms. She further stated toothbrushes should be labeled and kept with the resident's toiletries.</p>	F 441		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 589 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 161</p> <p>14. Observation of the crash cart in the employee break room, on 03/16/10 at 10:00 AM, revealed four (4) tee shirts which were on the second shelf, a face mask which was unpackaged, and two (2) rebreather masks which were not maintained as evidence of tears in the packaging. Further observation revealed suction tubing with an expiration date of 2011. Interview, on 03/23/12 at 4:30 PM, with the DON/ICN revealed the staff had been told not to put anything on the crash cart and she would remove the tee shirts. Further interview revealed the expired supplies would need to be removed and she would replace the masks which were not packaged properly.</p> <p>15. Observation on environmental tour, on 03/13/12 at 10:40 AM, revealed a stack of folded mechanical lift slings neatly folded on the toilet next to the sink in the shower room. Interview at the time with CNA #6 revealed she had placed the slings on the sink and they may have fell on to the toilet. She confirmed the slings had been laundered and were to be placed in the clean linen closet. Further observation revealed a box of disposable underwear (Tena pads) on the shower room floor. Interview with the DON, who was in the shower room at the time, revealed the Tena pads should not be on the floor and the laundered slings should never have been placed on the toilet due to infection control issues.</p> <p>16. Observation of the medication room, on 03/15/12 at 9:30 AM, revealed a box of Sodium Chloride vials in a box on the floor and a box of urinary specimen cups in a box on the floor. Further observation of the medication room revealed an intravenous ( IV) tubing set with an</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 162</p> <p>expiration date of 2009 and a ultraharte valve IV connector with an expiration date of 2009 in a drawer. There was also a bottle of Hydrogen Peroxide which was open and undated on top of the treatment cart available for use in the medication room. Interview, on 03/15/12 at the time of observation of the medication room with LPN #3, revealed the boxes of supplies should not be stored on the floor and the IV supplies should be removed from the room due to expiration. Continued interview revealed she was unsure how long the Hydrogen Peroxide was good to use after opening; however, she would need to throw the bottle away because it was not dated when opened.</p> <p>The facility's failure to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment in order to prevent the development and transmission of disease and infection was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 03/16/12 and determined to exist on 03/16/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/23/12 with the facility alleging removal of the Immediate Jeopardy on 03/17/12.</p> <p>A review of the facility AOC revealed the following:</p> <p>1. Upon return of Resident #5 with the infection to the facility, the roommate was encouraged to change rooms. On 03/15/12 at approximately.</p>	F 441		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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 441	<p>Continued From page 163</p> <p>11:45 AM, the ED spoke with the resident involved via cordless phone to explain potential risks related to staying in the room with the resident who had an infection. The resident refused to change rooms and staff educated the resident on the potential risks.</p> <p>2. The facility had the company they contract with for medical waste removal pick-up on 03/7/12, 03/16/12, and on 03/21/12. The waste was bagged and boxed according to state and federal guidelines. The storage area was re-arranged, with all clean products covered to prevent contamination as part of the facility's on-going QA program, the Housekeeping Supervisor will daily (Monday through Friday) monitor the amount of medical waste present and will alert the ED if an additional pick up is required. The Housekeeping Supervisor will daily (Monday through Friday) monitor the storage area to ensure clean products are covered to prevent contamination. On the weekend, the charge nurse will assume this responsibility.</p> <p>3. The staff was instructed in an inservice held on 03/16/12, to clean all hard surfaces (toilets, sink, and sink handles) with Virex/Oxivir and allow one minute wet time before wiping clean. The Virex/Oxivir was kept in a locked metal box under the resident's sink in the bathroom of those resident's in isolation. A competency check off was immediately done for all staff members, (nursing, housekeeping, and therapy); these staff were observed and deemed competent by the DON or charge nurse, before providing care to residents in isolation.</p> <p>4. All residents were monitored for signs and</p>	F 441		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360		
(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 441	<p>Continued From page 164</p> <p>symptoms of infection on an ongoing basis, utilizing the Interact two (2) programs, which includes the early warning tool that was utilized by all staff to identify any change in residents' condition, including signs and symptoms of infection.</p> <p>5. An in-service was conducted on 03/16/12 by the Licensed Nursing Home Administrator (LNHA) and the DON, reviewing isolation precautions, VRE, MRSA, donning and removing of PPE, hand washing, cleaning the environment surfaces (sink, commode, and faucets) with Virex/Oxivir and a contact time of one (1) minute prior to wiping. Staff in attendance of this in-service was all nursing staff, housekeeping, maintenance, administrative staff, and contracted therapy staff except for one LPN who was on vacation, who will be in-serviced and competency tested prior to returning to work.</p> <p>6. The DON or charge nurse will monitor hand washing, donning and disrobing of PPE, cleaning hard surfaces, and a wet time for cleaning at least once per day for the next ninety (90) days and then weekly thereafter if a resident requires isolation. Any issues identified will be reviewed with the LNHA and the Medical Director, and in return taken to the QA committee to develop an action plan for any identified issues identified.</p> <p>The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows:</p> <p>*Interview with the Resident #5 on 03/27/12 at 10:00 AM, revealed staff had encouraged him/her to change rooms related to the risk of exposure to</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360</b>		
(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 441	<p>Continued From page 165</p> <p>Infection and he/she did not want to change rooms.</p> <p>*Observation, on 03/26/12 at 4:00 PM, revealed four (4) boxes of medical waste stored in the soiled utility room, after being bagged and placed in a box, and sealed with tape and clean supplies they were covered with plastic. Interview with the Housekeeping Supervisor, on 03/27/12 at 10:00 AM, revealed she monitors the amount of medical waste on a daily basis (Monday through Friday), and if the facility needs to add an additional pick up she is to alert the ED. Further interview with the Housekeeping Supervisor revealed she was also to monitor the storage area to ensure clean products were covered to prevent contamination; this was to be done on a daily basis (Monday through Friday). On the weekends, the charge nurse was to monitor these areas. Review of the monitoring documentation validated that the Housekeeping Supervisor was monitoring as alleged.</p> <p>*Interview with the DON, on 03/27/12 at 3:00 PM, revealed all staff had to demonstrate a return demonstration of cleaning hard surfaces before providing care for residents in isolation. She further stated the key to the lock box's which contained the Virex/Oxlvir was placed on the key ring carried by the licensed nursing staff and before entering a resident's room who was in isolation, staff were to notify the licensed nursing staff for the key to the lock box. Review of the staff check off sheet for the return demonstration revealed all staff had been checked off by the DON or the Charge nurse by 03/16/12.</p> <p>*Review of the Interact two (2) form revealed staff</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360		
(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 441	<p>Continued From page 166</p> <p>was educated on 03/27/12 on the signs and symptoms of infections listed, along with early warning signs of infection. Interview with the DON, on 03/27/12 at 3:00 PM, revealed the interact two (2) forms were the facility's tool used by all staff if they noticed a change in the resident. Visitors were shown the form and encouraged to utilize it if they noticed a change in the resident.</p> <p>*Interview with the DON, on 03/27/12 at 3:00 PM, and review of the in-service documentation content and sign-in sheet revealed on 03/16/12 she and the LNHA conducted an in-service with all nursing staff, all housekeeping staff, all maintenance staff, all administrative staff, and all contracted therapy staff with exception of one LPN which was on vacation at the time of the in-service but would be in-serviced before allowed to return to work. Review of the in-service, revealed the facility had in-serviced staff on isolation precautions, VRE, MRSA, donning and disrobing of PPE, hand-washing, cleaning the environmental surfaces with Virex/Oxivir, and a contact time of one (1) minute prior to wiping and all staff had to do a return demonstration of the skill before they were able to provide care for the resident's. Interview with the Housekeeping Supervisor, on 03/27/12 at 10:00 AM, interview with Housekeeper #1, on 03/27/12 at 10:30 AM, interview with CNA #10, on 03/27/12 at 11:15 AM, interview with CNA #3, on 03/27/12 at 11:30 AM, interview with LPN #6, on 03/27/12 at 1:30 PM, interview with LPN #1, on 03/27/12 at 1:45 PM, interview with LPN #3, on 03/27/12 at 2:30 PM, interview with CNA #2, on 03/27/12 at 2:45 PM, interview with CNA #5, on 03/27/12 at 3:30 PM, interview with Maintenance Supervisor, on</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 441	Continued From page 167 03/27/12 at 4:30 PM, interview with CNA #3, on 03/27/12 at 5:00 PM, revealed staff had attended the in-service, and was knowledgeable of the material covered in the in-service.  *Observation, on 03/27/12 at 4:00 PM, revealed staff entering a resident's room who was in isolation. Staff was observed to don PPE and after she provided care to the resident, she disposed of her PPE in the resident's trash can and washed her hands prior to exiting the resident's room.  *Interview with the DON, on 03/27/12 at 3:00 PM, revealed as part of the on-going QA program, hand washing, donning and disrobing PPE, cleaning of hard surfaces, and wet time for cleaning will be monitored at least once per day for the next ninety (90) days and then weekly thereafter by the charge nurse or herself. She further stated any issues identified were reviewed with the LNHA and the Medical Director, then the concern will be addressed with the QA committee and in turn develop an action plan for those concerns identified.	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 469	F469 It is and was the policy of Hilltop Lodge to maintain an effective pest control program so that the facility is free of pests and rodents.  1. No residents were affected by the fruit flies and medical waste.  2. The fruit flies were treated on the following dates: 3/13/12; 3/16/12 and medical waste pickups were on 3/7/12; 3/16/12; 3/21/12. All medical	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 469

Continued From page 168

review of Centers for Disease Control and Prevention (CDC) guidelines, and the facility's policy, it was determined the facility failed to ensure there was an effective pest control program in order for the facility to be free of pests.

Observation in the kitchen revealed flying insects were flying around the large garbage can outside the dish machine area. Further observation revealed a fly landed on the food preparation table adjacent to the trash can.

Observation further revealed flying insects were noted to be inside and around a medical waste box which contained a biohazard bag of medical waste from residents with known diagnoses of Vancomycin Resistant Enterococcus (VRE) and Methicillin Resistant Staph Aureus (MRSA) located in the Soiled Utility Room.

Additionally, observation revealed flying insects in the employee break room. Interviews with staff revealed the flying insects had been in the facility for months. However, there was no documented evidence the pest control program had targeted the infestation of flying insects until after the start of the Reicensure and Recertification Survey on 03/13/12.

The findings include:

According to the Centers for Disease Control and Prevention (CDC) guidelines, insects can serve as agents for the mechanical transmission of microorganisms, or as active participants in the disease transmission process by serving as a vector.

F 469

wastes are bagged, boxed, and stored according to state and federal guidelines. All areas of the facility have been examined and treated per the pest control contractor.

3. Maintenance will continue to monitor the facility for fruit flies and treat them as needed. Medical waste is being removed from the facility on a routine scheduled basis. The maintenance director accompanies the pest control company on facility rounds. A log is completed any time that pests are noted in the facility. An inservice was conducted with all licensed staff on 3/16/12 which discussed medical waste disposal this was done by Stacey Richardson, LNHA, and Marcia Stamm, RN.

4. As part of the facility's ongoing quality assurance program the housekeeping supervisor will daily (Monday through Friday) monitor the amount of medical waste present and will alert the Executive Director if an additional pick up is required. Daily the Maintenance Director will monitor the buildings for fruit flies (for the next 10 days) and then weekly thereafter to monitor with

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 469

Continued From page 169

Review of the facility's "Pest Control" Policy, revealed the facility was to have a pest control contract that provides frequent treatment of the environment for pests, which would allow for additional visits when a problem was detected. Further review revealed there was to be emphasis on the pest control program in the kitchen, cafeterias, laundries, and other areas prone to infestation. Monitoring of the environment was to be done by facility's staff and pest control problems were to be reported promptly to the contractor.

Review of the facility's "Regulated Medical Waste Management" policy, dated 2012, revealed storage shall be in a locked location which affords protection from animals, insects, and weather conditions; and which minimizes exposure to the public.

Interview, on 03/17/12 at 10:00 AM, with the Executive Director revealed the facility had a pest control contract and the facility was serviced monthly by the contracted company. She stated the facility could also call the company between visits if problems were noted.

Observation, on 03/15/12 at 7:15 PM, revealed there were seven (7) large boxes labeled biohazard medical waste in the soiled utility room. The Housekeeping/Laundry Supervisor opened a partially taped biohazard box that was located in the soiled utility room. The box was partially taped with masking tape and not fully sealed. Two flying insects were observed to be flying around in the box which contained a closed red biohazard bag.

F 469

facility for pests. This process will be ongoing.

5. 3/30/12

3/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 469	<p>Continued From page 170</p> <p>Interview with the Housekeeping/Laundry Supervisor at that time of the observation revealed the biohazard box contained biohazard medical waste such as gowns, gloves, and masks that had been used by staff caring for residents with infections. Further observation revealed a flying insect flew out of the box and to the hopper spicket which was in the soiled utility room. Continued interview with the Housekeeper/Laundry Supervisor at the time revealed the spicket dispensed water mixed with various cleaning chemicals that housekeeping staff poured into their cleaning buckets. She stated the flying insects had been in the building for a week or a week and a half prior to the survey.</p> <p>Observation, on 03/16/12 at 10:20 AM, of the soiled utility room revealed there were still seven (7) large boxes labeled biohazard medical waste and flying insects were noted flying around the room.</p> <p>Interview, on 03/23/12 at 3:50 PM, with Certified Nursing Assistant (CNA) #11 revealed the flying insects were everywhere including the employee breakroom, resident rooms, and the dining room. She stated they had been a problem for months.</p> <p>Interview, on 03/23/12 at 4:00 PM, with the Office Manager revealed she had seen the flying insects in the building about a month before the survey started and the pest control company as well as maintenance had been working on the problem. She stated the bugs were much better now since the survey started.</p>	F 469		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 589 OWINGSVILLE, KY 40360
---	---

(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 469	<p>Continued From page 171</p> <p>Observation, on 03/17/12 at 4:10 PM. in the kitchen revealed a flying insect around the prep table in the middle of the kitchen. The flying insect landed on the prep table and Cook #2 motioned the insect away. Observation, on 03/20/12 at 9:45 AM, revealed flying insects around the large trash can outside of the dish machine area. Interview with the Dietary Manager, at that time, revealed the flying insects had been in the kitchen for two (2) to three (3) weeks and the pest control exterminator was in the building last week. Interview, on 03/20/12 at 9:50 AM, with Dietary Aide #2, revealed the flying insects had been in the kitchen for three (3) to four (4) weeks and the exterminator had been in the past week and told staff to dry out the floor mats which were on the kitchen floor in the dish machine area.</p> <p>Interview, on 03/23/12 at 4:02 PM, with Dietary Aide #1 revealed she had seen the flying insects in the kitchen, and dining room for the past couple of months.</p> <p>Interview, on 03/23/12 at 4:04 PM, with Dietary Cook #2 revealed she had seen flying insects everywhere including the kitchen, dining room and resident rooms for at least two (2) to three (3) months.</p> <p>Interview, on 03/15/12 at 11:50 AM, with the Maintenance Director revealed the problem with the flying insects just started and he had ordered an enzyme which he received 03/14/12, to put down all the drains in the building which he received 03/14/12. He further stated the exterminator came in on a regular basis monthly and was called on 03/14/12 to come to the facility</p>	F 469		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	---	---------------	---	----------------------

F 469	<p>Continued From page 172 related to the flying insects. He stated the exterminator told him to use bleach to pour down the drains; however, he did not want to use bleach due to the fumes.</p> <p>Observation of the employee break room, on 03/13/12 at 11:00 AM, revealed flying insects around the table and sink areas. Further observation during the survey from 03/13/12 through 03/29/12 revealed the flying insects were still in the employee break room.</p> <p>Interview, on 03/23/12 at 4:00 PM, with CNA #5 revealed she had seen the flying insects in the employee break room for at least a couple of months.</p> <p>Observation of the resident dining room on 03/26/12 at 4:30 PM, revealed there was a flying insect flying around the vending machine.</p> <p>Interview, on 03/23/12 at 11:50 AM, with the owner of the pest control company/contractor which serviced the facility, revealed the company was first notified of the flying insects which were actually "fruit flies" on 03/13/12. He stated a service technician was sent to the facility; however, could not find the source of the fruit flies and no recommendations were made. Further interview, revealed he was called by the facility on 03/16/12 related to the fruit flies, and came to the facility himself and checked the building. Continued interview revealed, the contractor found the source which was the dish machine in the kitchen. He stated there was water standing on the floor under and behind the dish machine. Continued interview revealed there was fifteen (15) to twenty (20) fruit flies flying around the dish</p>	F 469		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 469	<p>Continued From page 173</p> <p>machine and the trash can which did not have a lid, and was located near the dish machine. Further interview revealed his recommendation was for the facility to clean the kitchen floor under the dish machine, wash the kitchen walls, and obtain a lid for the trash can. He further stated, standing water and food particles were a source for fruit flies. Continued interview, revealed he had recommended an enzyme to be placed down all the drains and in the mop water. The contractor stated, if the source and environment for the fruit flies was eliminated, they would not be able to survive. Further interview revealed fruit flies was not really a concern for the pest control company, but more of a sanitation problem.</p> <p>Review of the Pest Control invoice, dated 03/16/12, revealed an extra service call for fruit flies. The invoice stated there was an inspection of all bathrooms, laundry room, soiled utility room, and kitchen. Further review revealed the dishwasher area in the kitchen had standing water underneath. Recommendations included cleaning and drying out the floor.</p> <p>Interview, on 03/17/12 at 10:00 AM, with the Executive Director revealed the facility became aware of the flying insects on 03/13/12 which was the first day of the survey and the exterminator was there the same day.</p> <p>Further interview, on 03/23/12 at 12:00 PM, with the Maintenance Director, revealed the pest control exterminator came in for their regular monthly visit on 03/13/12 and he notified the exterminator of the flying insects then. The Maintenance Director stated he was notified of the flying insects for the first time on 03/13/12 and</p>	F 469		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360</b>		
(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 469	Continued From page 174 had not noticed them until that date. Further interview revealed, on 03/16/12, the owner of the pest control company came to the facility and walked around the entire building. He stated the exterminator found water standing in the kitchen floor under the dish machine and found moisture behind the rubber baseboard around the wall near the dish machine. Continued interview, revealed he was unsure where the water was coming from but could not find a leak with the dish machine. Further interview, verified the trash can in the kitchen near the dish machine had no lid, and a lid was bought to fit the trash can. Continued interview revealed the owner of the pest control company had recommended an enzyme to be put down all the drains in the building and he had done that on 03/18/12 and had since noted an improvement with the flying insects.	F 469			
F 490 SS=K	<b>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</b>  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policies it was determined the facility's Administration failed to ensure the facility was administered in a manner that enabled it to use	F 490	<b>F490</b> It is and was the on the day of survey the policy of Hilltop Lodge to effectively maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  1. Policies and procedures related to infection control, waste management, and lab management have been reviewed with license staff. Those residents receiving anticoagulant therapy and those diagnosed with CHF and being reviewed daily to ensure appropriate		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 490

Continued From page 175  
its resources effectively and efficiently to attain or maintain the highest practicable, physical, or psychosocial well-being of each resident. The facility's Administration failed to have an effective system in place to ensure programs and policies and procedures were implemented.

The facility's Administration failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in order to prevent the development and transmission of disease and infection as evidenced by the facility failing to have an effective system to track and trend infections for causative organisms and to specify if infections were community or facility acquired infections. The facility failed to ensure residents were promptly treated with antibiotics for multi-drug resistant infections, and placed in isolation as per facility policy. Resident #8 had a urine culture collected on 02/16/12 which identified growth of Vancomycin Resistant Enterococcus (VRE) on 02/18/12. However, the facility failed to recognize and treat the resident with antibiotic therapy until a second urinalysis was collected which identified the same organism on 02/29/12. Resident #5 was immuno-suppressed related to a diagnosis of Diabetes; however, Resident #5 shared a room with Resident #8 who had a known diagnosis of VRE (urine) and was in Contact Isolation. The facility failed to ensure staff was knowledgeable related to hand hygiene for residents in Contact Isolation. Additionally, the facility Administration failed to ensure the Infection Control Nurse provided oversight related to the handling and/or processing of linens/clothing to prevent the spread of infection, disposal of medical waste, hand hygiene, and proper infection control

F 490

care is being provided. Resident #19 was transferred from the facility on 3/28/12. The Administrator will enforce all policies and procedures related to the alleged deficient practices. The Administrator is involved in the facility's Quality Improvement process.

2. All resident records of those who have a diagnosis of CHF and other residents with chronic conditions which would require ongoing monitoring have been reviewed to ensure appropriate care is being provided. The Administrator was actively involved in the process of reviewing all resident records and approved corrective action plans.

3. An inservice was conducted on March 28, 2012 at 5:00p.m. to review signs and symptoms of CHF and physician notification of weight changes of 5 percent in 30 days and 10 percent in 180 days (gain or loss). The inservice was be conducted by Stacey Richardson RN, BSN, LNHA. All licensed staff were in attendance, with the exception of two LPNs which work other jobs. These two LPNs were inserviced prior to returning to work on March 31, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 176</p> <p>technique related to residents on contact isolation. The facility failed to ensure there was an effective process for tracking and trending of causative organisms of infections and community or facility acquired infections. (Refer to F-441)</p> <p>The facility failed to have an effective system in place to ensure care and services were provided based on resident assessment and the comprehensive plan of care. Resident #1's Physician ordered an increase of Coumadin from 3.0 milligrams (mg) to 5.0 mg every day, on 01/06/12. On 01/08/12, Resident #1's Physician ordered the resident to be given 50 mg Levaquin everyday for five (5) days. The pharmacy notified the facility of a potential drug interaction with Coumadin and Levaquin for Resident #1, on 01/08/12, with recommendations to monitor INR and watch for bleeding. There was no evidence the facility notified the Physician of the pharmacy's recommendations in order for the Physician to make a decision to alter treatment. On 02/01/12 at 12:00 PM, Resident #1 told the Director of Nursing (DON) he/she passed some blood in his/her stool. There was no evidence the facility immediately notified the Physician or assessed the resident. On 02/02/12 at 8:10 AM, Resident #1 was sent to the hospital via ambulance, and required 10 mg of Vitamin K by slow intravenous (IV) infusion in the emergency room and four (4) units of Red Blood Cells (RBC). The resident was admitted to the hospital and diagnosed with Anemia from Acute Upper Gastrointestinal Bleed due to Coumadin Toxicity. Resident #4 who had a known diagnosis of Congestive Heart Failure (CHF), had a 10.2 pound weight gain from 03/05/12 through 03/10/12 and was assessed by the facility to have.</p>	F 490	<p>and April 2, 2012. The Administrator conducted the above inservice. The Administrator is actively involved in the facility's Quality Improvement Program to ensure corrective action is taken and sustained.</p> <p>4. As part of the facility's on-going Quality Assurance program the Administrator or Executive Director (Monday through Friday) and the charge nurse (Saturday and Sunday) will daily review all resident charts of those individuals who have a diagnosis of CHF to ensure proper care and services are being provided. These audits will be performed for the next 90 days and then weekly thereafter. Signs and symptoms of CHF are being monitored for each resident and their plan of care is being followed. The Administrator is reviewing audits daily to ensure they are up to date. The audits will be completed as outlined in the plan of correction and monitored by the Administrator for the specific time frames detailed in the plan of correction.</p> <p>5. 3/30/12</p>	3/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 177</p> <p>edema in the lower extremities. There was no documented evidence the facility notified the Physician or the Registered Dietitian (RD) of the resident's weight gain. On 03/19/12 the facility obtained another weight which revealed Resident #4 had an additional weight gain of 5.8 pounds and again there was no documented evidence the Physician was notified of the additional weight gain. The facility assessed the resident on 03/19/12 as having shortness of breath with edema in the lower extremities and the resident was transferred to the hospital emergency room and was hospitalized with a diagnosis of CHF Exacerbation with Pulmonary Edema a Hypoxia. The resident expired on 03/24/12. (Refer to F-157, F-282, F-309, F-325)</p> <p>The facility failed to have an effective system in place to provide adequate supervision when the risk of resident to resident altercation was identified to ensure supervision was provided. Resident #19 who had a history of aggressive behaviors, had three (3) episodes of aggressive behaviors. On 12/31/11, Resident #19 slapped Resident #5 in the face. There was no documented evidence the facility notified the resident's state appointed guardian. On 03/04/12, Resident #19 experienced another episode of aggressive behavior and slapped Unsampled Resident D in the face and again on 03/24/12, Resident #19 was involved in a situation with another resident (Resident #11). During the altercation, Resident #19 drew back his/her fist to strike Resident #11. Documentation revealed the state guardian was notified of the incidents on 03/04/12 and 03/24/11; however, interview with the state guardian revealed he had no knowledge of any of the incidents, except the 12/31/12</p>	F 490		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 178 Incident. (Refer to F-157, F-280, F-323)</p> <p>The facility's failure to have an effective administration placed residents at risk for serious injury, harm, impairment or death.</p> <p>Immediate Jeopardy and Substandard Quality of Care was identified in the area of Quality of Care 483.25 (F-300, F-323, and F-325 at a S/S of a "J"). Immediate Jeopardy was also identified at Resident Rights 483.10 (F-157 at a S/S "J"), Resident Assessment 483.20 (F-280 and F-282 at a S/S of a "J"), Infection Control 483.65 (F-441 at a S/S of a "J"), and 483.75 Administration (F-490 and F-520 at a S/S of a "K") during the Standard Survey conducted 03/13/12 through 03/26/12 and the Extended Survey conducted 03/26/12 through 03/29/12.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 03/23/12 for the Immediate Jeopardy identified during the Standard Survey conducted 03/13/12 through 03/26/12, with the facility alleging removal of the Immediate Jeopardy on 03/18/12. On 03/27/12, the Immediate Jeopardy was verified to be removed on 03/18/12 as alleged.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 03/28/12 for the Immediate Jeopardy identified during the Extended Survey conducted 03/26/12 through 03/29/12, with the facility alleging removal of the Immediate Jeopardy on 03/29/12. On 03/29/12, the Immediate Jeopardy was verified to be removed on 03/29/12 as alleged.</p> <p>The scope and severity of the Immediate</p>	F 490		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 569 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 179</p> <p>Jeopardy deficiencies at a "J" was lowered to a "D" and the scope and severity of the Immediate Jeopardy deficiencies at a "K" was lowered to a "E", while the facility develops, implements, and monitors a Plan of Correction to prevent recurrence.</p> <p>The findings include:</p> <p>1. Based on observation, interview, record review of Centers for Disease Control and Prevention (CDC) guidelines, and the facility's policy and procedure, it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infections. Review of the facility's infection control program and interview with the Director of Nursing (DON)/Infection Control Nurse (ICN), on 03/16/12 at 5:15 PM and 03/21/12 at 10:30 AM revealed the following findings in areas of infection prevention and control:</p> <p>Review of the facility's surveillance data related to the tracking and trending of infections, revealed the facility failed to ensure accurate tracking and trending to include reviewing organisms for patterns of infection, failed to track infections as facility acquired or non facility acquired, and failed to track each infection. In addition, the facility did not act on patterns of infections to implement interventions in an attempt to prevent further infections. The DON/ICN stated infections were tracked monthly through reports of residents on antibiotics received from the pharmacy, and also the lab sent a monthly report of any specimen cultures in order to identify the organism. However, she stated she did not look at the</p>	F 490		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 180</p> <p>organism for patterns of infection, but by type of infections itself such as Urinary Tract Infections (UTI's) or Upper Respiratory Infections (URI's) and did not track if the infection was acquired inside or outside of the facility. Further interview revealed although there was a pattern of ten (10) UTI's noted in 01/12 and 02/12, she did not implement interventions to correct the concern which was identified such as an in-service related to handwashing, glove changes, and peri-care.</p> <p>The facility's infection control program revealed there was a lack of infection control oversight related to the transporting and processing of linens and monitoring of water temperatures for the laundry. Staff interviews revealed washing machine temperatures were not checked and infection control procedures in the laundry were not being monitored. Interview on 03/15/12 at 12:30 PM with the Executive Director, revealed there was no separate room for the dirty laundry bins to be stored, and she acknowledged the dirty laundry bin was parked right in front of the washing machine and in close proximity to the dryer. Continued interview with the ED, revealed she was aware the laundry staff were not taking washing machine temperatures and there was no way to test the temperature.</p> <p>The facility failed to have an effective infection control program in the area of medical waste. Observation of the soiled utility room on 03/14/12 at 5:00 PM revealed there was an accumulation of seven (7) boxes of biohazard medical waste noted on the floor and stacked up. Interview with the DON/ICN revealed although the facility had increased their pick up by the biohazard waste company she would consider seven (7) boxes of</p>	F 490		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 181</p> <p>medical to be an accumulation. She stated this medical waste was from residents who had diagnoses of Vancomycin Resistant Enterococcus (VRE) and Methicillin Resistant Staph Aureus (MRSA). Interview on 03/14/12 at 5:15 PM with the ED, revealed the biohazard pickup for the medical waste was at the facility on 03/07/12 and the facility was contracted for twelve (12) pick ups a year. She stated she called the company that day for a pickup, but it may take a few days for a pickup once the company was notified.</p> <p>Observations and interviews with staff, revealed staff were not trained and knowledgeable in infection control techniques needed to care for residents who were in contact isolation in a manner which would prevent the spread of the organisms to residents who shared bathrooms with residents who were in contact isolation. Resident #8 was diagnosed with MRSA of the sputum. Interview with the DON/ICN revealed staff emptied Resident #8's urinary catheter bag into a urinal, emptied the urinal into the toilet in the resident's bathroom, (which connected with room D 17 shared by Resident #13 and Resident #15). She stated, staff then rinsed the urinal in the sink and poured the contents into the commode. Continued interview with the DON/ICN revealed Resident#8 was diagnosed with Vancomycin Resistant Enterococcus (VRE) of the urine and had a colostomy bag which staff emptied into a bed pan and then emptied the contents into the commode of the bathroom being shared by his/her roommate (Resident #5). Further interview with the DON/ICN, revealed the staff could use Virex (a disinfectant that kills VRE and MRSA after emptying the urine (Resident #6)</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 182</p> <p>and feces (Resident #8) into the commodes of their shared bathrooms. However, she had not specifically in-serviced the staff related to disinfecting after these practices in an attempt to prevent the other residents who use the bathrooms from being contaminated. Further interview with the DON/ICN revealed she had not done any audits of hand hygiene practices and had not done any recent in-services related to contact precautions although it would be important to refresh the staff on proper procedures with the Multi-Drug Resistant Organisms.</p> <p>Additionally the facility failed to ensure the labs were monitored to ensure residents were placed on appropriate antibiotics. Resident #6 had lab specimens from both his/her sputum and urine, collected on 02/28/12, which revealed MRSA organisms isolated from the residents sputum. However, there was no antibiotics orders and no documented evidence of follow up of the MRSA result. Lab specimens were again collected on 03/11/12 and the sputum lab culture identified a heavy growth of MRSA. The resident did not receive antibiotics for the MRSA of the sputum until 03/16/12. Resident #8 had a urine culture collected on 02/16/12 which identified growth of VRE on 02/18/12; however, the facility failed to recognize and treat the resident with antibiotic therapy until a second urinalysis was collected which identified the same organism on 02/29/12. Interview with the DON/ICN stated there was no process in place to ensure as the ICN she had reviewed all the laboratory results and taken action as needed.</p> <p>Interview with the Executive Director (ED) on</p>	F 490		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 821 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360	
(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 490	<p>Continued From page 183</p> <p>03/27/12 at 4:30 PM, revealed she was unable to answer questions related to tracking and trending infections because the DON/ICN was responsible for this. Further interview with the ED revealed the team leader for the environmental and the clinical team had not identified any of these infection control issues and these issues should have been identified by these team leaders as they did rounds at the facility. (Refer to F-441).</p> <p>2. Based on interview, and record review, it was determined the facility failed to have an effective system to ensure residents on Coumadin (anticoagulant medication) therapy were monitored to ensure the appropriate dosage of Coumadin was maintained. A review of the 2011 Lippincott, Williams and Wilkins Nursing Drug Handbook revealed a black box warning that "Coumadin can cause major or fatal bleeding which is more likely to occur during the starting period and with a higher dose. Regularly monitor INR in all patients."</p> <p>A review of the facility's policy titled, "Anti Coagulant Protocol", undated, revealed Physician inquiries for residents receiving Coumadin therapy should include the nurse verbalizing to the Physician "this resident is on Coumadin therapy". This would serve as a reminder to the Physician to select a treatment plan that less interfered with the Coumadin therapy. In addition, review of the protocol revealed each resident receiving Coumadin would have an individual log maintained regarding their treatment regimen and the log would reflect resident current Coumadin dose; lab results of PT/INR levels; Physician decision to change dose or maintain, and the next scheduled lab: PT/INR date to be recorded.</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360		
(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 490	Continued From page 184  Review of the PDR 2011 Edition Nurse's Drug Handbook, available at the facility, revealed Levaquin may increase PT and cause bleeding episodes with Warfarin (Coumadin).  Review of Resident #1's medical record revealed orders to have Resident #1's Coumadin increased from 3 mg to 5 mg everyday and to have a PT/INR drawn on 01/11/12. Review of Physician's Orders, dated 01/08/12 at 5:20 PM revealed orders for Resident #1 to receive 750 mg Levaquin (antibiotic medication) for an Upper Respiratory Infection everyday for five days. The pharmacy notified the facility of a potential drug interaction with Levaquin and Coumadin and the need to monitor INR and watch for signs of bleeding through a fax which was received at the facility at 8:01 PM on 01/08/12, revealed the pharmacy alerted the facility of a potential drug interaction with Coumadin and Levaquin. However, there was no evidence the facility notified the Physician of the pharmacy's recommendations. On 02/01/12 at 12:00 PM, Resident #1 informed the Director of Nursing (DON) he/she passed some blood in his/her stool. However, there was no documented evidence the facility immediately notified the Physician or assessed the resident. On 02/02/12 at 8:10 AM, Resident #1 was noted to be weak and unresponsive at times and had blood in his/her urine and stool. Resident #1 was transferred to the hospital via ambulance, received 10 mg of vitamin K by slow IV infusion in the emergency room, received four (4) units of Red Blood Cells (RBC) upon admission to the hospital and was diagnosed with Anemia from Acute Upper Gastrointestinal Bleed from	F 490			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 186 Coumadin Toxicity.</p> <p>Interview with Resident #1's Physician, on 03/16/12 at 3:15 PM and on 03/20/12 at 2:30 PM, revealed he would have expected when Resident #1 informed the staff there was blood in the resident's stool, that he would have been notified as well as the nurse should have taken vital signs. Additional interview revealed when he made rounds with the nurse he was not told about Resident #1 reporting there was blood in the resident's stool. He indicated if he had been made aware of Resident #1 having blood in the stool, he would have also ordered a PT/INR to be obtained. (Refer to F-309)</p> <p>3. Based on observation, interview, and record review, it was determined the facility failed to ensure care and services were provided to attain and maintain the resident's highest practicable physical well-being for Resident #4 who had a known diagnosis of Congestive Heart Failure (CHF).</p> <p>Resident #1 had a Comprehensive Plan of Care related to CHF with interventions to observe and monitor for weight gain unrelated to intake; however, there was no documented evidence the Physician was notified of this residents significant weight gains. Review of the Weights and Vitals Summary Report revealed the resident had a weight gain of 10.2 pounds from 03/05/12 through 03/10/12, and an additional weight gain of 5.8 pounds from 03/10/12 through 03/19/12 (sixteen (16) pounds in fourteen (14) days). On 03/19/12 at 11:00 AM, LPN #3 notified the Physician of Resident #4's respirations being slightly labored and of the resident's lower extremities being very</p>	F 490		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 186</p> <p>swollen. LPN #3 stated she did not notify the Physician of weight gain and was unaware of the resident having weight gain. The resident's respirations were labored and his/her oxygen saturation was eighty-eight to eighty-nine percent (88-89%) with oxygen in place. The Physician was called and orders were received to send the resident to the emergency room. Resident #4 was admitted and diagnosed with Diastolic Congestive Heart Failure with Exacerbation, and Chronic Obstructive Pulmonary Disease. Interview with the Attending Physician/Medical Director, revealed he was unaware of the resident having weight gains in 03/2012 and if he had been notified of the weight gain he would have checked a BNP lab test. Further interview revealed he would have ordered Lasix (diuretic medication) had he known of the weight gain; however he was not notified of the resident's weight gain until the resident's condition "had gotten out of hand" and she/he had to be diuresed at the hospital. He further stated he would have attempted other avenues of care and interventions if he had known of the weight gain, and stated the weight gain played a vital role in the resident's CHF status.</p> <p>Interview on 03/28/12 at 1:30 PM with the Executive Director and the Nurse Consultant, revealed it was acknowledged the Physician should have been notified of Resident #4's weight gains in 03/12 and the Plan of Care should have been followed related to monitoring weight. Further interview revealed this was deficient practice. (Refer to F-325)</p> <p>4. Based on observation, interview, and record review, it was determined the facility failed to</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 490	<p>Continued From page 187</p> <p>ensure supervision to prevent accidents. Review of the facility's policy titled, "Behavior Tracking Protocol" revealed each resident would be monitored for certain behavior indicators determined by the Minimum Data Set Assessment process which include verbally abusive, physically abusive and socially inappropriate behaviors. Continued review revealed a behavior tracking flow sheet would be kept and the specific behavior indicator should be marked on the behavior tracking flow sheet. The frequency of the behaviors would be recorded by the number of times the behavior occurred. If further stated, observed behaviors should be noted by any discipline and reported to nursing. Then social services and nursing would review for patterns and concerns in behaviors that had the potential to affect the residents' overall psychosocial status and care delivery. It further revealed behaviors that had a negative impact on residents would be addressed in the residents' plan of care. In addition the protocol indicated the facility should collaborate with the residents' Physician as behaviors occurred in order to determine the treatment plan.</p> <p>Interview and record review revealed, on 12/31/11, at approximately 8:00 PM, Resident #19 called Resident #5 (his/her roommate) names and then slapped him/her in the face causing facial redness. Although the facility separated the residents and changed Resident #19's room assignment, there was no documented evidence the facility implemented sufficient interventions to prevent the recurrence of Resident #19's aggressive behaviors towards other residents. On 03/04/11, facility staff observed Unsampled Resident #D attempting to</p>	F 490		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490

Continued From page 188

touch Resident #19 on the hand during meal service, as a in response Resident #19 reached and slapped Unsampled Resident D across the face. There was no documented evidence the facility implemented sufficient interventions to prevent the recurrence of the continued aggressive behaviors of Resident #19. On 03/24/11, Resident #11 was observed by facility staff waiting to enter the restroom when Resident #19 walked around Resident #11 and entered the restroom first. In response, Resident #11 yelled at Resident #19 and Resident #19 yelled back and drew back his/her fist in an attempt to hit Resident #11.

Interview with the DON, on 03/27/12 at 2:55 PM, revealed the resident's Plan of Care was not updated and no new interventions were put into place following the aggressive behavior incident that occurred on 12/31/11. Continued interview revealed, the Plan of Care should have been updated and revised with each behavioral episode for appropriateness.

Interview with the Executive Director, on 03/28/12 at 8:30 AM, revealed the facility was aware of Resident #19's previous behavioral situations, but did not recognize there was any intent on Resident #19's behalf. Continued interview revealed, the facility should have attempted other avenues of care for Resident #19 instead of maintaining the current level of care. There was no documented evidence Resident #19 had been seen by any psychiatry services prior to 03/27/12, when the resident was transferred to a local Hospital. (Refer to F-323)

Review of the AOC revealed the following:

F 490

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 189</p> <p>1. On 03/16/12, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON)/Infection Control Nurse (ICN) conducted an in-service reviewing isolation precautions, VRE, MRSA, donning and disrobing of PPE, hand-washing, cleaning the environment surfaces, with Virex/Oxivir TB, and contact time of one (1) minute prior to wiping.</p> <p>An in-service with all housekeeping and laundry staff was conducted on 03/16/12 at 2:30 PM by the LNHA and the Maintenance Director providing instruction to obtain laundry temperatures at least once per shift to ensure the temperature is above ninety-five (95) degrees Fahrenheit and maintain a log of the temperatures. A privacy screen has been put in place to ensure separation of clean and dirty laundry areas.</p> <p>An in-service was conducted with all licensed staff on 03/17/12 at 1:00 PM by the LNHA and the DON to review physician notification, anticoagulant therapy, signs and symptoms of bleeding along with proper physical assessment, as well as documentation requirements.</p> <p>On 03/28/12, a in-service was conducted by the LNHA at 5:00 PM to review the signs and symptoms of CHF and physician notification of weight changes of five percent (5%) in thirty (30) days and ten percent (10%) in one-hundred and eighty (180) days (gain or lose), for all licensed staff with the exception of two (2) LPN's who were working at other jobs but will be in-serviced prior to returning to work on 03/31/12 and 04/2/12.</p> <p>On 03/28/12, an in-service was conducted with all</p>	F 490		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P. O BOX 869 OWINGSVILLE, KY 40360
---	--

(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 490	<p>Continued From page 190</p> <p>licensed nursing staff with the exception of two LPN's which would be in-service before returning to work. The in-service was related to the behavior monitoring program and tracking of behaviors, as well as physician and family notification of such behaviors. Information covered in the in-service included what to do if a resident to resident altercation occurred, licensed staff will initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors are exhibited one (1) on one (1) supervision and immediate psychiatric evaluation will take place. The licensed staff was instructed to immediately notify the ED or the LNHA if resident to resident physical altercations took place to ensure resident safety.</p> <p>2. As part of the facility's on-going Quality Assurance (QA) program, the DON or charge nurse will monitor hand washing, donning and disrobing of PPE, cleaning hard surfaces, and a wet time for cleaning at least once per day for the next ninety (90) days and then weekly thereafter if a resident requires isolation.</p> <p>The Housekeeping Supervisor will daily (Monday through Friday) monitor the amount of medical waste present and will alert the ED if an additional pick up is required. The Housekeeping Supervisor will daily (Monday through Friday) monitor the storage area to ensure clean products are covered to prevent contamination. On the weekend, the charge nurse will assume this responsibility.</p> <p>The Housekeeping Supervisor will audit the laundry room for proper separation of clean and dirty laundry, and washer temperature logs daily</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 191            (Monday through Friday) for the next ninety (90) days and then at least weekly. On the weekends the charge nurse will conduct these audits.</p> <p>On a daily basis the LNHA or ED (Monday-Friday) and the Charge Nurse (Saturday and Sunday), will review all resident charts of those residents who have a diagnosis of CHF, to ensure the signs and symptoms of CHF are being monitored for each resident, that their Plan of Care was being followed, and proper care and services was being provided. These audits will be performed for ninety (90) days and then weekly thereafter.</p> <p>The Social Service Director (SSD) will daily (Monday through Friday) review the behavior monitoring/tracking log to ensure that they are being completed properly, the administrative staff member who is on call will monitor on Saturday and Sunday. The chart of any resident who was exhibiting behaviors was reviewed by the SSD to ensure there was no resident to resident contact, and communicate with the MDS coordinator/Administrator to update the care plan interventions if behavior was exhibited.</p> <p>The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows:</p> <p>*Interview with the DON on 03/27/12 at 3:00 PM, revealed on 03/16/12 she and the LNHA conducted an In-service with all nursing staff, with exception of on LPN which was on vacation at the time of the In-service but would be In-serviced before allowed to return to work, all housekeeping staff, all maintenance staff, all administrative staff, and all contracted therapy staff. Review of</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 490	<p>Continued From page 192</p> <p>the in-service, revealed the facility had in-serviced staff on isolation precautions, VRE, MRSA, donning and disrobing of PPE, hand-washing, cleaning the environmental surfaces with Virex/Oxivir TB, and a contact time of one (1) minute prior to wiping.</p> <p>*Further interview with the DON, revealed as part of the on-going QA program, hand washing, donning and disrobing PPE, cleaning of hard surfaces, and wet time for cleaning will be monitored at least once per day for the next ninety (90) days and then weekly thereafter by the charge nurse or herself.</p> <p>*Interview with the Housekeeping Supervisor, on 03/27/12 at 10:00 AM, revealed she monitors the amount of medical waste on a daily basis (Monday through Friday), and if the facility needs to add an additional pick up she is to alert the ED. Further interview with the Housekeeping Supervisor revealed she was also to monitor the storage area to ensure clean products are covered to prevent contamination; this is to be done on a daily basis (Monday through Friday). On the weekends, the charge nurse was to monitor these areas.</p> <p>*Review of the "On the Spot" in-service, conducted on 03/16/12, revealed all laundry and housekeeping staff working was in-serviced, with materials covering keeping the privacy curtain up to keep the dirty and clean laundry separated, maintaining a temperature log, ensuring the temperatures were maintained at ninety-five (95) degrees Fahrenheit or above, and immediate notification of the LNHA or the Maintenance Director and to halt laundry services if the</p>	F 490		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 490	<p>Continued From page 193            temperature drops below ninety-five (95) degrees Fahrenheit</p> <p>*Further interview with the Housekeeping Supervisor, on 03/27/12 at 10:00 AM, revealed she would be doing audits of the laundry room for proper separation and washer temperature logs daily (Monday through Friday) for the next ninety (90) days and then at least weekly, and on the weekend the charge nurse would be doing the audits</p> <p>*Continued interview with the DON, on 03/27/12 at 3:00 PM, revealed all licensed staff was in-serviced on physician notification, anticoagulant therapy, signs and symptoms of bleeding along with proper physical assessment, as well as documentation requirements. Review of the in-service sign in sheet, titled "Documentation Guidelines with Physician Notification", revealed all licensed staff attended the in-service.</p> <p>*Continued interview with the DON, on 03/27/12 at 3:00 PM, revealed she had been reviewing the medical records of all residents receiving anticoagulant therapy daily to ensure proper assessment of the resident's concerns, documentation which detailed care provided to resident met current professional standards and the physician was notified. She further stated she would be doing the audits daily for thirty (30) days and then weekly thereafter. Review of the audit form, titled Audit of Resident Records, revealed all medical charts of resident's receiving anticoagulant therapy was reviewed on a daily basis and was ongoing.</p>	F 490		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 859 OWINGSVILLE, KY 40360
---	---

(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 490	<p>Continued From page 194</p> <p>*Review of the audit titled, "Review of Residents with CHF" on 03/29/12, revealed daily audit of the resident chart's for resident's with CHF was conducted on 03/28/12, and was ongoing. Interview with the LNHA, on 03/29/12 at 10:45 AM, revealed she planned to continue to perform the audits daily (Monday through Friday) and the charge nurse to review on Saturday and Sunday, for the next ninety (90) days and then weekly thereafter.</p> <p>*Further interview with the LNHA, on 03/29/12 at 10:45 AM, revealed she conducted an in-service, titled "Residents with CHF", which covered checking for edema, taking vital signs and oxygen saturations, other signs and symptoms to monitor for, documentation, monitoring weights, and when to notify the physician of weight changes, for all licensed staff on 03/28/12 at 5:00 PM, with the exception of LPN #7 who would be in-serviced before she was allowed to return to work.</p> <p>*Review of the monitor titled, "Behavior Monitoring/Tracking Log" on 03/29/12, revealed daily audit of the resident chart's for resident's with behaviors was conducted on 03/28/12, and was ongoing. Interview with the Social Service Director (SSD), on 03/29/12 at 10:30 AM, revealed she planned to continue to perform the audits daily (Monday through Friday) and the Administrative staff member who was on call to review on Saturday and Sunday.</p> <p>*Interview with the LNHA, on 03/28/12 at 10:45 AM, revealed she had conducted an in-service with all licensed staff on 03/28/12 at 5:00 PM, with the exception of LPN #7 who would be in-serviced before returning to work. Reviewed in</p>	F 490		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40380	

(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 490	Continued From page 195 the in-service, the behavior monitoring program and tracking of behaviors, as well as physician and family notifications of such behaviors, if a resident to resident altercation occurs, licensed staff was in-serviced to initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors are exhibited one (1) on one (1) supervision and immediately psychiatric evaluation will take place, and to immediately notify the ED or LNHA if resident to resident physical altercations take place to ensure resident safety.  *Interview with the LNHA, on 03/29/12 at 10:00 AM, revealed as part of the facility's on-going QA program any concerns identified with these monitors will be brought to her and the Medical Director, and in turn will develop an action plan for any identified issues.	F 490		
F 502 SS=D	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure laboratory services were obtained to meet the needs of it's residents for one (1) of five (5) sampled residents on Coumadin therapy, in the selected sample of twenty-four (24) residents (Resident #13).  Resident #13 had Physician's orders for a	F 502	F502 It is and was on the day of survey the policy of Hilltop Lodge Nursing and Rehabilitation to provide or obtain laboratory services to meet the needs of its residents.  1. Resident #13 remains in facility. No adverse effects were noted related to the delay in the lab test, the PT/INR obtained on 2/24/12 was within the therapeutic range.  2. All lab orders have been reviewed and scheduled according to orders. 3. An inservice was conducted on 3/17/12 by the Administrator and	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360	
(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 502	<p>Continued From page 196</p> <p>Prothrombin (PT) and International Normalized Ratio (INR), (tests used to make necessary medication adjustments in Coumadin dosage to keep blood levels within the therapeutic range and to monitor the effectiveness of Coumadin therapy) to be drawn on 02/23/12; however, the PT/INR was not drawn until 02/24/12.</p> <p>The findings include:</p> <p>Review of the facility policy, titled "Lab Monitoring System", dated 11/02/07, revealed labs ordered were to be placed in a lab calendar by the nurse who received the order. Medical Records staff was to check the calendar daily and complete a lab requisition for the labs that needed to be drawn the next morning. In addition, a tickler file was to be maintained by medical records for routine labs. A copy of the lab requisition was to be maintained in a notebook at the nurse's station until the lab results were returned and reported to the Physician. The copy would be removed from the notebook by the nurse after he/she reports the results to the Physician. As part of the Quality Assurance audit, the Director of Nursing (DON) would audit a sampling of resident charts for lab orders, lab results and physician notification of lab results.</p> <p>Review of Resident #13's clinical record revealed diagnoses which included a History of a Deep Vein Thrombosis (DVT) of the Right Leg with Pulmonary Embolism, and Cerebral Vascular Accident (CVA). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/27/12, revealed the facility assessed the resident as having moderate impairment in cognitive skills:</p>	F 502	<p>Director of Nursing pertaining to laboratory policy and services. A laboratory calendar has been implemented, as well as an urgent clip board has been put in place so that all laboratory requisitions are not removed from the clip board until results are obtained and the physician is notified.</p> <p>4. As part of the facility's ongoing Quality Assurance the Director of Nursing will monitor, on a monthly basis, ten percent of all labs ordered to make sure they are obtained as ordered. This process will continue for the next six months.</p> <p>5. 3/30/12</p>	3/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 502	<p>Continued From page 197</p> <p>Review of Physician's orders, dated 02/17/12, revealed orders to repeat the PT/INR for 02/23/12. However, review of the laboratory data revealed the PT/INR was drawn on 02/24/12 with a value of Prottime 14.4 high (reference range 9.5-11.8) and INR 1.4 high (reference range of 0.9-1.1).</p> <p>Interview, on 03/23/12 at 3:30 PM, with Licensed Practical Nurse (LPN) #12, revealed she transcribed lab orders to the lab calender book and then filled out lab requisition slips and placed them in the lab box under the date the lab was to be drawn. She stated she had transcribed the PT/INR to be drawn on 02/24/12 instead of 02/23/12 into the lab book. Review of the lab book revealed the PT/INR was transcribed to be drawn on 02/24/12.</p> <p>Interview, on 03/23/12 at 3:46 PM, with the DON revealed she was unaware of the error related to the PT/INR for Resident #13 being transcribed incorrectly to the lab calendar and lab requisition slip. She further stated the facility used the Anticoagulant Coumadin Log to ensure the PT/INR's were drawn as ordered, however there was no system in place to ensure the nurse who took off the order transcribed the lab orders to the lab calender book and filled out the lab requisition slip with the correct date such as a twenty-four (24) hour check to ensure all Physician's orders were transcribed correctly for labs.</p>	F 502		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each</p>	F 514	<p>F514 It is and was on the day of survey the policy of Hilltop Lodge to maintain clinical records on each resident in accordance with accepted professional standards and practices</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 569 OWINGSVILLE, KY 40360
---	---

(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 514	<p>Continued From page 198</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation; interview and record review, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurately documented for one (1) of twenty-four (24) sampled residents (Resident #4).</p> <p>Record review for Resident #4 revealed the Physician Order Form for re-admission on 01/14/12 was dated as 12/2011 at the top of the Form. Interview revealed the facility utilized a pre-printed form with the incorrect date.</p> <p>The findings include:</p> <p>Review of the Physician's Order Form for Re-admission to the facility from the hospital for Resident #4 revealed a date on the bottom of the page of 01/14/12, which was handwritten. Review of the date at the top of the page revealed a date which was typed, December 2011.</p>	F 514	<p>that are complete, accurately documented, readily accessible, and systematically organized.</p> <ol style="list-style-type: none"> <li>1. Resident #4 returned to the facility following the hospitalization of 3/19/12. Following subsequent hospitalizations the resident has since died.</li> <li>2. All order forms which have preprinted dates have been removed.</li> <li>3. Licensed staff has been in-serviced by the pharmacy and Director of Nursing on 3/29/12 discussing proper forms to be utilized when admitting and readmitting residents.</li> <li>4. As part of the facility's ongoing Quality Assurance program the Director of Nursing will audit all admissions and readmissions within seventy-two hours to ensure proper forms have been utilized. Medical records will monthly audit 10% of all records to ensure clinical records are maintained on each resident in accordance with accepted medical standards. These audits will continue indefinitely.</li> <li>5. 3/30/12</li> </ol>	3/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360</b>
--	---

(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 514	Continued From page 199 Interview, on 03/22/12 at 2:30 PM, with the Director of Nursing (DON) revealed someone had pulled the Physician's Order Form which was dated December 2011 by mistake to write the Physician's Orders for 01/14/12. She stated the pharmacy left blank Physician's Order Forms for the staff to use when there was a re-admission, and staff should have pulled a blank Physician's Order Form. She was unaware of the error.	F 514		
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	F520 It is and was on the days of survey the policies of Hilltop Lodge to maintain a quality assurance committee which meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.  1. The facility implemented all aspects of the plan of correction dated 3/8/11 and quality assurance studies have been completed in areas of identified deficiencies prior to this survey. The Quality Assurance Committee has been re-educated to conducting studies and follow-up studies by the Executive Director on 4/5/12. All areas of deficient	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 200</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies and review of the facility's Plan of Correction (POC) with a compliance date of 03/08/11, it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evident by repeat deficiencies cited at an Immediate Jeopardy level due to the facility's failure to ensure the Physician was notified related to a significant changes in residents' physical condition and/or a need to alter treatment significantly; and failure to ensure necessary care and services were provided related to a resident receiving coumadin therapy not receiving the necessary monitoring and a resident with Congestive Heart Failure (CHF) not receiving the necessary care and services after exhibiting a substantial weight gain. In addition a repeat deficiency was cited at a wide spread level related to the facility's failure to ensure dietary sanitation. This was further evident by additional deficiencies cited at an Immediate Jeopardy level when the facility's failure to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection; failure to ensure care plans were followed; failure to ensure care plans were reviewed an revised after a</p>	F 520	<p>practice and residents affected have been reviewed by the Quality Assurance team to ensure corrective action.</p> <p>2. All Quality Assurance team members were re-educated on conducting meaningful studies on 4/5/12 by Heather O'Banion, LNHA, Executive Director. By completing the audits mentioned in the plan of correction and auditing all resident changes the Quality Assurance committee has identified other possible residents involved. The facility has not identified any significant issues related to specific residents. The committee has been actively involved in corrective action steps for each cited deficiency.</p> <p>3. Prior to each Quality Assurance meeting the Executive Director will review the studies conducted and the results of each study. The Quality Assurance committee which includes the Executive Director, Administrator, Medical Director, Director of Nursing, Social Services, Dietary Manager, Housekeeping Supervisor, Maintenance Director, Activity Director, and Office Manager, meets monthly reviewing</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 520

Continued From page 201  
resident displayed aggressive behavior towards other residents; failure to provide supervision to ensure a safe environment related to a resident with aggressive behaviors; and failure to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, mental or psychosocial well-being of each resident.

Immediate Jeopardy was identified on 03/16/12 and was determined to be removed on 03/17/12 and 03/18/12 after an acceptable credible Allegation of Compliance (AOC) was received and further observations, in-service record reviews, audit reviews and staff interviews were conducted to verify removal of the Immediate Jeopardy. Immediate Jeopardy was identified again on 03/28/12 and was determined removed on 03/29/12, after an acceptable credible Allegation of Compliance (AOC) was received and further observations, in-service record reviews, audit reviews and staff interviews were conducted to verify removal of the Immediate Jeopardy on 03/29/12, prior to exit.

The scope and severity of the Immediate Jeopardy deficiencies at a "J" was lowered to a "D" and the scope and severity of the Immediate Jeopardy deficiencies at a "K" was lowered to a "E", while the facility develops, implements, and monitors a Plan of Correction to prevent recurrence.

The findings include:

1. Based on observation, interview, and record review, it was determined the facility failed to

F 520

all studies detailed in the plan of correction.

4. As part of the facility's ongoing Quality Assurance Program a member of the facility's management governing body will attend the next six Quality Assurance meetings to ensure studies have been conducted and corrective actions are implemented as planned. This process will continue for the specific audits detailed in the plan of correction for the next six months however Quality Assurance measures will be ongoing.

5. 4/6/12

4/6/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520	<p>Continued From page 202</p> <p>establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. This was evident by, record review of the infection control data and interview with the Infection Control Nurse on 03/15/12, which revealed seven (7) urinary tract infections (UTI's) in February 2012 were identified; however, she failed implement and document actions to resolve the related problem. Further interview with the Infection Control Nurse revealed there was not an effective process for tracking and trending of causative organisms of infections and community or facility acquired infections. Also, the Infection Control Nurse failed to provide oversight related to employee hygiene, pest control, waste disposal and handling and/or processing linens to prevent spread of infection. In addition, observation, record reviews and interviews revealed Resident #8 had a urine culture collected on 02/16/12 which identified growth of Vancomycin Resistant Enterococcus (VRE) on 02/18/12; however, the facility failed to recognize and treat Resident #8 with antibiotic therapy until a second urinalysis was collected and failed to place Resident #8 in contact isolation. In addition, review of Resident #8's medical chart, revealed on 03/01/12 a sputum culture was completed which identified growth of Methicillin-Resistant Staph Aureus (MRSA) organism; however, the facility failed to provide evidence of follow up with the Physician regarding treatment.</p> <p>In addition, interview with laundry staff on 03/15/12, revealed the facility failed to obtain washing machine temperatures to ensure the sanitizer was effective and observation on</p>	F 520		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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 520

Continued From page 203  
03/15/12, revealed there was no separation between the clean and dirty laundry areas. Further, observation on 03/14/12, of the Soiled Utility Room revealed an accumulation of seven (7) large boxes of medical waste and there was no segregation of the medical boxes from the clean equipment such as mop heads and brooms, and fruit flies were observed in this area around the medical waste boxes.

In addition, observation on 03/15/12, revealed Resident #5, who was immune-suppressed related to a diagnosis of Diabetes, was in the room with Resident #8 who was known to have VRE in the urine and in contact isolation. In addition, observation on 03/15/12, revealed staff exiting Contact Isolation Rooms without washing their hands, and a staff seated on a resident's bed who had been identified with MRSA without adequate coverage of the PPE, potentially contaminating their clothing.

In addition, interview on 03/15/12 with the Director of Nursing/Infection Control Nurse (DON/ICN), revealed staff emptied Resident #6's urinary catheter into a urinal and then into the toilet, then rinsed the urinal in the sink. Further interview revealed staff emptied Resident #8's colostomy bag into the urinal and then rinsed the urinal in the sink, and did not decontaminate the sink or toilet following these practices even though the bathroom was utilized by other residents and both residents (Resident #6 and #8) were in Contact Isolation. In addition, observation on 03/14/12, revealed improper infection control technique related to a dressing change for Resident #3 and observation on 03/14/12, revealed poor hand hygiene related to a

F 520

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION. A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 821 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 204</p> <p>skin assessment for Resident #1 and Resident #3 was observed. A staff member failed to wash her hands after administering medication to Resident #7 and prior to administration of medication to unsampled Resident A, and a staff was providing feeding assistance to Resident #2 and was observed touching the 10 mm syringe with her bare hands prior to insertion into the resident's drink.</p> <p>In addition, observation on 03/13/12, revealed clean folded lift slings on top of the toilet in the shower room, disposable underwear (Tena-pads) in a box on the shower room floor, two (2) urinals hanging on the trash can unlabeled and undated and a wash basin located on the bathroom floor in a semi private resident room D1-17, an emesis basin on the back of the toilet which was unlabeled in a semi private room D3-3, a box of urine collection specimen containers located on the floor of the medication room, as well as expired/outdated intravenous tubing in the medication room, two (2) packages of Attends located on the floor in the hall Storage Room, and four (4) lose t-shirts located on the shelf of the crash cart, a face mask which was not packaged, and two (2) re-breather masks with tears in the packaging. In addition, review of the medical chart, revealed Resident #1's admission Tuberculin (TB) Skin Test was completed on 08/07/10 and the follow up annual TB skin test was not done until 02/07/11.</p> <p>Interview with the ED, on 03/27/12 at 4:30 PM, revealed the Director of Nursing (DON) was the one who would track and trend the infections in the facility and would bring the information gathered to the QA meetings for the committee to</p>	F 520		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 569 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 205</p> <p>review. She further stated she was unable to answer any questions related to the tracking and trending of infections because this was part of the DON's responsibilities. Further interview with the ED revealed the team leader for the environmental and the clinical team for the QA Committee had not identified any of above identified areas and these areas should have been identified by the team leaders as they did their rounds of the facility.</p> <p>2. Review of the facility's POC, with a compliance date of 03/10/11, revealed all residents' medical charts would be assessed by the DON, as it related to examining all residents and interviewing residents for any changes in their conditions. Further review of the POC, revealed any concerns faxed to the Physician would be recorded on the daily communication/report sheet and the oncoming shift would review any concerns faxed to the Physician and followed up on that shift and the DON would review the daily communication/report sheet daily Monday-Friday as a secondary QA check to ensure follow up had occurred. Further review of the POC, revealed as part of the ongoing QA program the DON would review the Physician notifications on a weekly basis for six (6) months, and report all the findings to the ED, and the findings were reviewed by the QA Committee members for the next six (6) months to ensure compliance.</p> <p>Based on interview and record review, it was determined the facility failed to ensure the Physician was notified related to significant changes in the residents' physical condition and/or need to alter treatment significantly for</p>
-------	--

F 520

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 206</p> <p>three (3) of twenty four (24) sampled residents, (Resident #1, #4, and #2). This was a repeat deficiency for the facility, previously cited on 02/17/11. Review of Resident #1's medical chart revealed Resident #1's dose of Coumadin (a blood thinner) was increased on 01/06/12 and then was started on Levaquin (an antibiotic) on 01/08/12. Further review of the medical chart revealed the pharmacy made the recommendation to monitor the PT/INR (labs which evaluate the therapeutic level of the blood thinner) and there was no documented evidence the facility notified the Physician. Then on 02/01/12 Resident #1 complained of blood in the stool, and there was no documented evidence the Physician was notified of the change in condition. Resident #1 was sent to the Emergency Room (ER) on the morning of 02/02/12 and was admitted with Coumadin Toxicity and Gastrointestinal Bleed. Review of the medical chart revealed there was no documented evidence the Physician was not notified when Resident #4, who had a diagnosis of Congestive Heart Failure, had a weight gain of 10.2 pounds from 03/05/12 through 03/10/12. On 03/19/12 review of the medical chart revealed Resident #4 had an additional weight gain of 5.8 pounds and was sent to the Emergency Room and hospitalized for exacerbation of CHF. Interview with the Physician, on 03/27/12, revealed he was not notified of the weight gain. In addition, review of the medical chart for Resident #2, revealed red area noted on the bony prominence of the outer aspect of the left foot was identified on 07/17/11, and then on 02/07/12 documentation revealed the wound had changed to a deep purple color and increased in size. further review of the medical chart revealed no documented evidence the</p>	F 520		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40380		
(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 520	<p>Continued From page 207 Physician was notified.</p> <p>Interview with the ED, on 03/27/12 at 4:30 PM, revealed in the six (6) months the DON was reviewing the daily communication/report sheets there were no concerns identified; therefore, the daily reviews were stopped after the six (6) months. Further interview with the ED revealed staff was still using the daily communication/report sheets; therefore, the Physician should have been notified of all three (3) incidents related to changes in conditions.</p> <p>3. Based on interview and record review, it was determined the facility failed to ensure necessary care and services were provided to ensure ongoing monitoring for two (2) of twenty-four (24) sampled residents (Resident #1 and #4). Resident #1, who was on Coumadin therapy (blood thinning therapy) complained of blood in the stool on 02/01/12; however, there was no documented evidence of an assessment completed and no documented evidence the Physician was notified. The facility developed a Comprehensive Plan of Care for Resident #1 related to the resident receiving Coumadin therapy with interventions in place to report increased weakness, report bleeding gums, and blood in stool/urine. The facility failed to provide services according to the plan of care. In addition, the facility failed to notify the Physician related to the need for monitoring the Prothrombin (PT) and International Normalized Ratio (INR), (laboratory test used to make necessary medication adjustments in Coumadin dosage to keep blood levels within the therapeutic range) for Resident #1 after an increase in Coumadin dosage on 01/06/12, and after</p>	F 520			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 208</p> <p>pharmacy recommendations to monitor the INR and monitor for bleeding when Resident #1 was started on Levaquin (antibiotic medication) on 01/08/12. In addition, the facility failed to recognize or respond to a life threatening adverse consequence related to Coumadin therapy. Resident #1 was sent to the emergency room on 02/02/12 and admitted with diagnoses of Coumadin Toxicity and Gastric Intestinal Bleed.</p> <p>Resident #4 who had a diagnosis of Congestive Heart Failure (CHF) and a Plan of Care which stated staff was to observe and monitor for weight gain. Resident #4 sustained a significant weight gain of 10.2 pounds from 03/06/12 through 03/10/12; however, there was no documented evidence the Physician was notified of the weight gain. The resident sustained a further weight gain of 5.8 pounds from 03/10/12 through 03/19/12 and again there was no documented evidence the Physician was notified of the weight gain. On 03/19/12 the resident became short of breath, with labored respirations and had an increase in edema in the lower extremities. Resident #4 was admitted to the hospital on 03/19/12 with diagnoses of Exacerbation of Congestive Heart Failure with Pulmonary Edema, and Hypoxia. Resident #4 expired on 03/24/12 at the facility.</p> <p>Interview with the DON, on 03/22/12 at 2:30 PM, revealed residents with significant weight gain and/or loss were to be taken to the weekly Quality of Care Meeting and discussed by the interdisciplinary team; however, Resident #4 was not discussed in the meeting the week of 03/11/12 because there was no meeting held due to the start of the standard survey on 03/13/12.</p>	F 520		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520	<p>Continued From page 209</p> <p>Interview, on 03/28/12 at 1:30 PM, with the Executive Director and the Nurse Consultant; revealed it was acknowledged the Physician should have been notified of Resident #4's weight gains in 03/12 and the Plan of Care should have been followed related to monitoring weight. Further interview revealed this was deficient practice. When asked how she ensured the staff followed the care plans, she stated she made rounds to check on the residents; however, did not audit to ensure the Care Plans were followed.</p> <p>Interview with the ED, on 03/27/12 at 4:30 PM, revealed with the review of the daily communication/report sheets, these concerns should have been identified. She stated implementing Care Plans were not identified as concerns by the QA committee. She further stated these areas of concern should have been identified and brought to the QA committee for review.</p> <p>4. Based on interview and record review, it was determined the facility failed to provide adequate supervision, monitoring and revision of the Plan of Care for one (1) of twenty-four (24) sampled residents (Resident #19) in order to ensure a safe environment. Resident #19 had a history of abusing other residents and the facility failed to ensure each resident was protected from abuse as evidenced by the failure to identify residents with a personal history of being at risk of abusing other residents and developing intervention strategies in preventing occurrences and monitoring changes in Resident #19's aggressive behaviors on three (3) separate occasions and failure to reassess current interventions for appropriateness on a regular basis. Resident</p>
-------	---

F 520

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 210</p> <p>#19 exhibited three (3) different episodes of aggressive behaviors with two (2) of the incidents resulting in Resident #19 slapping one (1) unsampled resident and one (1) sampled resident in the face.</p> <p>Interview with the Executive Director, on 03/28/12 at 8:30 AM, revealed the facility assessed Resident #19 as having a Brief Interview of Mental Status (BIMS) score of a five (5), indicating severe cognitive impairment, and she felt he/she could not comprehend the issues. Further interview revealed, the facility was aware of Resident #19's previous behavioral situations, but did not recognize there was any intent on Resident #19's behalf. The facility failed to provide any documented evidence Resident #19 had been seen by any psychiatry services prior to 03/27/12, when the resident was transferred to a local Hospital. Continued interview revealed, the facility should have attempted other avenues of care for Resident #19 instead of maintaining the current level of care. Further interview with the ED, on 03/28/12 at 4:30 PM, revealed this concern was not identified in the QA meetings and should have been identified and addressed to protect other residents from the resident's aggressive behaviors.</p> <p>5. Review of the facility's Plan of Correction (POC), with a compliance date of 03/08/11, revealed food temperature logs would be implemented and monitored daily by the Dietary Manager. All dietary staff was in-serviced on 03/04/11 by the ED on proper sanitary conditions, including but not limited to the use of hair nets, proper storage/handling of food, and glove changing. The POC stated, the Dietary Manager</p>	F 520		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 859 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 211</p> <p>would daily (Monday-Friday) and the Cook (Saturday-Sunday) check food storage, cleanliness of equipment, compliance of temperature logs, and sanitary conditions of food handling and storage in the dietary department. As part of the facility's ongoing QA program dietary sanitation would be monitored monthly for six (6) months by the Dietary Manager to include weekly audits of trays at varying times to ensure proper food temperatures of the food. The Dietary Manager was auditing key areas for sanitation as a secondary check, included in this report was equipment sanitation and storage of food and utensils. These audits were to be reported to the ED to be reviewed to ensure compliance.</p> <p>Based on observation, interview, and record review it was determined facility failed to have an effective system to ensure dietary sanitation, when the facility failed to store, prepare and distribute food under sanitary conditions. This was a repeat deficiency for the facility, previously cited on 02/17/11. This was evident by, observation on 03/13/12, revealed food was being stored in the freezer not covered, unsanitary practices of obtaining food temperatures when the thermometer was not sanitized between taking temperatures and puncturing the foil wrap when obtaining the temperatures, and failure to test the temperatures of the pureed food. In addition, observation on 03/13/12, revealed the facility failed to prevent cross contamination by not ensuring sanitizing solutions to sanitize work areas and dishes were tested appropriately to prevent food-borne illness, staff in the dishwashing area not consistently sanitizing their hands when going from loading dirty dishes in the</p>	F 520		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40380
---	---

(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 520

Continued From page 212

dish washer to emptying clean dishes out of the dish washer, a staff person not sanitizing their hands after she touched her eyeglasses and then touched the oven knob and continued to prepare food trays, and fruit files in the kitchen landing on the trash can and also landing on the food preparation table.

Interview with the Dietary Manager, on 03/13/12 at 6:15 PM, revealed it was her and the Dietitian's responsibility to train staff on proper sanitation. She stated they had an in-service with kitchen staff in January 2012, but did not discuss the amount of bleach to put in the sanitation bucket to achieve proper sanitation levels. Further interview revealed they did not identify how staff were to measure the amount of bleach; did not have a measuring device; and only informed staff what the test strip should read. She stated she thought they were changing and testing the sanitizing bucket when they tested the sanitation solution in the three compartment sink and the sanitation bucket should have the proper sanitation solution for use. The DM stated it was obvious the staff needed more training.

Interview with the Dietitian, on 03/14/12 at 8:50 AM, revealed she performed audits every month in the kitchen area, but had not watched staff perform test of the sanitation bucket or sink. She indicated she was not used to having a separate solution for the sanitizing bucket, but when tested on her last audit it was one-hundred (100) ppm. The Dietitian stated it was a failure on her part not to have stressed the sanitation bucket with the staff at her in-service.

Interview with the ED, on 03/27/12 at 4:30 PM,

F 520

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 520	<p>Continued From page 213</p> <p>revealed the QA committee reviewed the monitors and audits conducted by the Dietary Manager, which were done for a six (6) month time period. She further stated through the monitors and audits, no concerns had been identified. Further interview with the ED revealed the facility's QA Committee was comprised of a representative from each department and was broken down into three (3) teams with a team leader for each: environment, operations, and clinical. She further stated these team leaders were out on the units observing their areas and talking to the staff to identify any concerns. Further interview revealed the deficiencies identified were not identified by the QA Committee nor brought to the QA Committee by any of the staff.</p> <p>6. Based on interview, record review and policy review, it was determined the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident, as evidenced by Immediate Jeopardy identified in the areas of 42 CFR 483.10 Resident Rights, 42 CFR 483.20 Resident Assessment, 42 CFR 483.25 Quality of Care, 42 CFR 483.65 Infection Control and 42 CFR 483.75 Administration and Substandard Quality of Care (SQC) identified in the area of 42 CFR 483.25 Quality of Care. The Administration failed to ensure policies and procedures were implemented, failed to identify the facility's system failures and failed to develop and implement appropriate action plans to ensure quality of care and correct identified deficiencies.</p>	F 520		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 214</p> <p>Interview with the ED, on 03/27/12 at 4:30 PM, revealed the administrative staff had not identified imminent concern in these areas prior to the survey. Further interview with the ED revealed the facility's QA Committee was comprised of a representative from each department and was broken down into three (3) teams with a team leader for each: environment, operations, and clinical. She further stated these team leaders were out on the units observing their areas and talking to the staff to identify any concerns. Further interview revealed the deficiencies identified were not identified by the QA Committee nor brought to the QA Committee by any of the staff.</p> <p>Review of the AOC, dated 03/23/12 and review of the AOC dated 03/28/12, revealed the as part of the facility's ongoing Quality Assurance program the following was implemented:</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing or Charge Nurse will monitor hand-washing, donning and disrobing of personal protective equipment (PPE), cleaning of hard surfaces and a wet time for cleaning at least once per day for the next ninety (90) days and then weekly thereafter if a resident requires isolation. Any issues identified will be reviewed with the Administrator and Medical Director. The Housekeeping Supervisor will audit the laundry room for proper separation and washer temperature logs daily (Monday through Friday) for the next ninety (90) days and then at least weekly. On the weekends the Charge Nurse will conduct these audits. Any issues will be reviewed with the Administrator and Medical Director. The Housekeeping Supervisor will daily (Monday-Friday) monitor the amount of Medical</li> </ol>	F 520		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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 520	<p>Continued From page 215.</p> <p>Waste and will alert the ED if additional pick up is required and daily (Monday-Friday) monitor the storage area to ensure clean products are covered to prevent contamination. On the weekends the Charge Nurse will assume this responsibility. Daily, for the next ten days, the Maintenance Director will monitor the building for fruit flies and treatment will be initiated as problems are noted.</p> <p>2. As part of the facility's on going Quality Assurance program the Administrator or DON will audit 100% of residents' charts that are currently receiving Coumadin Therapy or have a diagnosis of CHF daily for the next 30 days, and then weekly thereafter, to provide a double check to ensure proper assessment of residents' concerns, documentation which details care provided to each resident and that meets current professional standards, and Physician notification. Any issues identified will be reviewed with the Administrator and Medical Director. The QA committee will in-turn develop an action plan for any identified issue noted.</p> <p>3. As part of the facility's on going Quality Assurance program the Social Service Director will daily (Monday-Friday) review the Behavior Monitoring Tracking Log to ensure they are being completed properly, the Administrative staff member on call will monitor on Saturday and Sunday. The chart of any resident exhibiting behaviors will be reviewed by the SSD to ensure there is no resident to resident contact. The SSD will communicate with MDS Coordinator/Administrator to update care plan interventions if behaviors are exhibited.</p>	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 550 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 520	<p>Continued From page 216</p> <p>4. The Dietary Supervisor (Monday through Friday) and Cook (Saturday and Sunday) will check the sanitization solution for proper concentrations daily at various times. The Registered Dietitian will also audit these processes on a monthly basis. Any issues will be reviewed with the Administrator and Medical Director. In addition, the Dietary Supervisor will daily monitor the staff taking food temperatures to ensure proper technique is used when cleaning the thermometer with alcohol between each food tested. This practice will continue indefinitely. Any issues identified will be reviewed with the Administrator and Medical Director. The QA committee will in turn develop an action plan for any identified issue noted above.</p> <p>The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows:</p> <p>*Interview with the DON on 03/27/12 at 3:00 PM, revealed on 03/16/12 she and the LNHA conducted an in-service with all nursing staff, with exception of on LPN which was on vacation at the time of the in-service but would be in-serviced before allowed to return to work, all housekeeping staff, all maintenance staff, all administrative staff, and all contracted therapy staff. Review of the in-service, revealed the facility had in-serviced staff on isolation precautions, VRE, MRSA, donning and disrobing of PPE, hand-washing, cleaning the environmental surfaces with Virex/Oxivir TB, and a contact time of one (1) minute prior to wiping.</p> <p>*Further interview with the DON, revealed as part of the on-going QA program, hand washing,</p>	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 520	<p>Continued From page 217</p> <p>donning and disrobing PPE, cleaning of hard surfaces, and wet time for cleaning will be monitored at least once per day for the next ninety (90) days and then weekly thereafter by the charge nurse or herself.</p> <p>*Interview with the Housekeeping Supervisor, on 03/27/12 at 10:00 AM, revealed she monitors the amount of medical waste on a daily basis (Monday through Friday), and if the facility needs to add an additional pick up she is to alert the ED. Further interview with the Housekeeping Supervisor revealed she was also to monitor the storage area to ensure clean products are covered to prevent contamination; this is to be done on a daily basis (Monday through Friday). On the weekends, the charge nurse was to monitor these areas.</p> <p>*Review of the "On the Spot" in-service, conducted on 03/16/12, revealed all laundry and housekeeping staff working was in-serviced, with materials covering keeping the privacy curtain up to keep the dirty and clean laundry separated, maintaining a temperature log, ensuring the temperatures were maintained at ninety-five (95) degrees Fahrenheit or above, and immediate notification of the LNHA or the Maintenance Director and to halt laundry services if the temperature drops below ninety-five (95) degrees Fahrenheit.</p> <p>*Further interview with the Housekeeping Supervisor, on 03/27/12 at 10:00 AM, revealed she would be doing audits of the laundry room for proper separation and washer temperature logs daily (Monday through Friday) for the next ninety (90) days and then at least weekly, and on the</p>	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/29/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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)	(X6) COMPLETION DATE
F 520	<p>Continued From page 218 weekend the charge nurse would be doing the audits.</p> <p>*Continued Interview with the DON, on 03/27/12 at 3:00 PM, revealed all licensed staff was in-service on physician notification, anticoagulant therapy, signs and symptoms of bleeding along with proper physical assessment, as well as documentation requirements. Review of the in-service sign in sheet, titled "Documentation Guidelines with Physician Notification", revealed all licensed staff attended the in-service.</p> <p>*Continued interview with the DON, on 03/27/12 at 3:00 PM, revealed she had been reviewing the medical records of all residents receiving anticoagulant therapy daily to ensure proper assessment of the resident's concerns, documentation which detailed care provided to resident met current professional standards and the physician was notified. She further stated she would be doing the audits daily for thirty (30) days and then weekly thereafter. Review of the audit form, titled Audit of Resident Records, revealed all medical charts of resident's receiving anticoagulant therapy was reviewed on a daily basis and was ongoing.</p> <p>*Review of the audit titled, "Review of Residents with CHF" on 03/29/12, revealed daily audit of the resident chart's for resident's with CHF was conducted on 03/28/12, and was ongoing. Interview with the LNHA, on 03/29/12 at 10:45 AM, revealed she planned to continue to perform the audits daily (Monday through Friday) and the charge nurse to review on Saturday and Sunday, for the next ninety (90) days and then weekly</p>	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/29/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 859 OWINGSVILLE, KY 40360</b>		
(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 520	<p>Continued From page 219 thereafter.</p> <p>*Further interview with the LNHA, on 03/29/12 at 10:45 AM, revealed she conducted an in-service, titled "Residents with CHF", which covered checking for edema, taking vital signs and oxygen saturations, other signs and symptoms to monitor for, documentation, monitoring weights, and when to notify the physician of weight changes, for all licensed staff on 03/28/12 at 5:00 PM, with the exception of LPN #7 who would be in-serviced before she was allowed to return to work.</p> <p>*Review of the monitor titled, "Behavior Monitoring/Tracking Log" on 03/29/12, revealed daily audit of the resident chart's for resident's with behaviors was conducted on 03/28/12, and was ongoing. Interview with the Social Service Director (SSD), on 03/29/12 at 10:30 AM, revealed she planned to continue to perform the audits daily (Monday through Friday) and the Administrative staff member who was on call to review on Saturday and Sunday.</p> <p>*Interview with the LNHA, on 03/28/12 at 10:45 AM, revealed she had conducted an in-service with all licensed staff on 03/28/12 at 5:00 PM, with the exception of LPN #7 who would be in-serviced before returning to work. Reviewed in the in-service, the behavior monitoring program and tracking of behaviors, as well as physician and family notifications of such behaviors, if a resident to resident altercation occurs, licensed staff was in-serviced to initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors are exhibited one (1) on one (1) supervision and immediately psychiatric evaluation will take place, and to immediately</p>	F 520			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/29/2012
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 569 OWINGSVILLE, KY 40360		
(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 520	Continued From page 220 notify the ED or LNHA if resident to resident physical altercations take place to ensure resident safety.  *Interview with the LNHA, on 03/29/12 at 10:00 AM, revealed as part of the facility's on-going QA program any concerns identified with these monitors will be brought to her and the Medical Director, and in turn will develop an action plan for any identified issues.	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/15/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 660 OWINGSVILLE, KY 40360
---	---

(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
K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Survey under: NFPA 101 (2000 Edition)  Plan approval: 1870  Facility type: SNF/NF  Type of structure: Type III unprotected  Smoke Compartment: Two (2)  Fire Alarm: Fire alarm installed in 2001 Smoke detectors in Long and Short Hall corridors Heat detectors in Short Hall and Long Hall corridor and resident rooms  Sprinkler System: Complete sprinkler system (dry) installed 1977  Generator: Natural gas installed 2007  A standard Life Safety Code survey was conducted on 03/15/12. Hilltop Lodge was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was thirty seven (37). The facility is licensed for thirty nine (39) beds. The Highest Scope and Severity deficiency was an "F" level.	K 000	Hilltop Lodge does not believe nor does the facility admit that any deficiencies exist.  Hilltop Lodge reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Hilltop Lodge reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Hilltop Lodge does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding.	
K 056 88=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Heather Okanich</i>	TITLE Executive Director	(X6) DATE 5/30/12
---	-----------------------------	----------------------

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:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/15/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360
---	---

(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
--------------------	--	---------------	---	----------------------

K 056	<p>Continued From page 1</p> <p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the sprinkler system was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) smoke compartments, thirty nine (39) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 03/15/2012 at 10:07 AM, revealed the accelerator valve to the sprinkler system was in the off position. The accelerator allows the sprinkler system to activate in a timely manner. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 03/15/2012 at 10:07 AM, with the Maintenance Director, revealed he was unaware the accelerator valve was in the off position. A phone call from the Maintenance Director to the</p>	K 056	<p>Hilltop Lodge offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents.</p> <p>Hilltop Lodge strives to provide the highest quality care while assuring the rights and safety of all residents.</p> <p>K056 It is and was on the day of survey the policy of Hilltop Lodge for the sprinkler system to be in accordance with NFPA standards.</p> <ol style="list-style-type: none"> <li>1. The sprinkler valve was switched to the "on" position after talking with the sprinkler inspection company.</li> <li>2. The entire system was checked by maintenance to ensure it was functioning properly.</li> <li>3. All maintenance staff were instructed on 3/15/12 regarding the proper positioning for the sprinkler valve.</li> </ol>	
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186307	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  03/15/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 521 EAST HIGH STREET, P O BOX 659 OWINGSVILLE, KY 40360
---	---

(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
K 056	<p>Continued From page 2</p> <p>sprinkler inspection company revealed the accelerator valve should be in the on position.</p> <p>Reference: NFPA 25 ( 1998 edition )                      9-4.4.1.2 Gauges shall be inspected weekly.                      (a) The gauge on the supply side of the dry pipe valve shall indicate that the normal supply water pressure is being maintained.                      (b) The gauge on the system side of the dry pipe valve shall indicate that the proper ratio of air or nitrogen pressure to water supply pressure is being maintained in accordance with the manufacturer ' s instructions.                      (c)* The gauge on the quick-opening device, if provided, shall indicate the same pressure as the gauge on the system side of the dry pipe valve.                      Exception: Systems equipped with low air or nitrogen pressure alarms shall be inspected monthly.                      9-4.4.2.4* Quick-opening devices, if provided, shall be tested quarterly.</p>	K 056	<p>4. As part of the facility's ongoing Quality Assurance Program the maintenance staff will check the sprinkler valve weekly to ensure it is in the "on" position.</p> <p>5. 3/30/12</p>	3/30/12