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FORM APPROVED
OMB NO. 0938-0391

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 000	INITIAL COMMENTS AMENDED A Standard Survey was conducted 03/13/12 through 03/26/12 and an Extended Survey was conducted 03/26/12 through 03/29/12. Four (4) different Immediate Jeopardy situations were identified during the survey. Immediate Jeopardy and Substandard Quality of Care (SQC) was determined to exist on 12/31/11 at 42 CFR 483.25 Quality of Care, F-323 at a Scope and Severity (S/S) of a "J" and 42 CFR 483.20 Resident Assessment, F-280 at a S/S of a "J". The facility failed to ensure adequate supervision to ensure residents' safety related to a resident that exhibited aggressive behaviors towards other residents. Resident #19, who had been declared incompetent and had a state guardian, slapped Resident #5 on the left side of the face on 12/31/11. Although the facility attempted to transfer the resident out for psychiatric evaluation; the resident refused the transfer. There was no documented evidence the Care Plan was revised to include interventions to prevent the recurrence of Resident #19's aggressive behaviors towards other residents. On 03/04/12, Resident #19 slapped Unsampled Resident D on the face and on 03/24/12, Resident #19 was noted to be yelling at Resident #11 with his/her fist drawn back in an attempt to hit the other resident. Interview with the State Guardian revealed the facility had not informed him of Resident #19's aggressive behaviors. The facility's failure to protect residents from abuse was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was verified removed effective 03/29/12 as	F 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.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather O'Banion 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.

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F 000	Continued From page 1 alleged in the facility's credible Allegation of Compliance (AOC). Immediate Jeopardy and SQC was determined to exist on 01/08/12 at 42 CFR 483.10 Resident Rights, F-157 at a S/S of a "J", 42 CFR 483.20 Resident Assessment, F-282 at a S/S of a "J", and 42 CFR 483.25 Quality of Care, F-309 at a S/S of a "J". The facility failed to ensure the necessary care and services were provided to attain or maintain the highest practicable physical well being for a resident. 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. 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 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. The facility's lack of adequate monitoring of residents on Coumadin therapy was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was verified removed effective 03/18/12 as alleged in the facility's	F 000	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. Hilltop Lodge strives to provide the highest quality care while assuring the rights and safety of all residents.	

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F 000	Continued From page 2 credible AOC. Immediate Jeopardy was determined to exist on 02/16/12 at 42 CFR 483.65 Infection control, F-441 at a S/S of an "J". The facility 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. 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. In addition, the resident was not place in contact isolation until 02/29/12. The facility failed to ensure residents who were immunosuppressed were not sharing rooms with residents who were diagnosed with multi-drug resistant organisms. 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 technique related to residents on contact	F 000		

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F 000	Continued From page 3 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. The Immediate Jeopardy was verified removed effective 03/18/12 as alleged in the facility's credible AOC. Immediate Jeopardy and SQC was determined to exist on 03/10/12 at 42 CFR 483.50 Resident Rights, F-157 at a S/S of a "J", 42 CFR 483.20 Resident Assessment, F-282 at a S/S of a "J", and 42 CFR 483.25 Quality of Care, F-309 at a S/S of a "J" and F-325 at a S/S of a "J". The facility failed to ensure necessary care and services were provided for 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 03/05/12 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. The facility's failure to provide necessary care and services in accordance with acceptable standards of practice related to residents who had signs and symptoms of CHF, was likely to cause and/or has caused serious injury, harm, impairment or death. The	F 000		

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F 000	Continued From page 4 Immediate Jeopardy was verified removed effective 03/29/12 as alleged in the facility's credible AOC. Based on the above findings, it was determined Immediate Jeopardy was identified to exist on 12/31/11 through 03/28/12, and was removed on 03/29/12. Deficiencies cited were 42 CFR 483.10 Resident Rights, F-157 at a S/S of a "J"; 42 CFR 483.15 Quality of Life, F-241 at a S/S of a "D"; 42 CFR 483.20 Resident Assessment, F-279 at a S/S of an "D", F-280 at a S/S of a "J", F-281 at a S/S of a "D", F-282 at a S/S of a "J"; 42 CFR 483.25 Quality of Care, F-309 at a S/S of a "J", F-314 at a S/S of a "D", F-323 at a S/S of a "J" and F-325 at a S/S of a "J"; 42 CFR 483.35 Dietary Services, F-371 at a S/S of an "F", 42 CFR 483.60 Pharmacy Services, F-431 at a S/S of a "D", 42 CFR 483.65 Infection Control, F-441, at a S/S of a "J", 42 CFR 483.70 Physical Environment, F-469 at a S/S of an "E", 42 CFR 483.75 Administration, F-490, at a S/S of a "K", F-502, at a S/S of a "D", F-514, at a S/S of a "D", and F-520 at a S/S of a "K". Substandard Quality of Care (SQC) was identified in the areas of 42 CFR 483.25, F-309, F-323 and F-325. The highest S/S was a "K". After Immediate Jeopardy was verified removed, based on the facility's two AOCs, 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 an "E", while the facility develops, implements, and monitors a Plan of Correction to prevent recurrence of the deficient	F 000		

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F 000	Continued From page 5	F 000		
	practice.			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	F157	
	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).		It is and was on the day of survey the policy of Hilltop Lodge to immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury, a significant change in the resident's physical, mental, or psychosocial status or need to alter treatment significantly.	
	The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.		1. Resident #1 remains in the facility. It should be noted that the physician who ordered the change in her Coumadin dose on 1/6/12 is the same physician who ordered the Levaquin on 1/8/12. A PT/INR was drawn on 1/11/12 which was therapeutic and faxed to the physician. Another order was received on 1/13/12 to repeat the PT/INR in one month. Resident #2 remains in the facility and the area in question is healed. Resident #4 returned to the facility following the hospitalization on 3/19/12. Following subsequent	
	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	This REQUIREMENT is not met as evidenced by:			

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F 157	Continued From page 6 Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure the the Physician and/or Responsible Party was notified related to changes in conditions/or need to alter treatment. In addition the facility failed to follow their policy entitled, "Changes in a Resident's Condition or Status" for four (4) of twenty-four (24) sampled residents (Resident #1, #19, #4, and #2). Resident #1's Physician ordered an increase of Coumadin from 3.0 milligrams (mg) to 5.0 mg every day, on 01/06/12, and ordered 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, be completed on 01/11/12. 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. The results of the PT/INR obtained on 01/11/12 were a PT of 30.3 seconds and an INR of 2.9 (normal range of PT 9.5-11.8 seconds and therapeutic range of INR 2.0-3.0). The results were faxed to the Physician on 01/11/12. The Physician faxed back to the facility, on 01/13/12, to obtain a PT/INR in one month. 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	F 157	hospitalizations the resident has since died. Resident #19 was transferred from the facility on 3/28/12. 2. All residents with Chronic Conditions are being monitored daily to ensure the resident's legal representative and physicians are being notified when significant changes or need to alter treatment significantly occurs. 3. Daily the Director of Nursing or charge nurse is monitoring residents with chronic conditions to ensure residents' treatment and proper notification of any treatment changes or change in condition occurs. An inservice was conducted on 3/28/12 at 5:00 p.m. reviewing physician notification. This inservice was conducted by Stacey Richardson RN, BSN, LNHA. All licenced staff were in attendance with the exception of the two LPN's which work other jobs. These two LPN's were inserviced on 3/31/12 and 4/2/12 (prior to returning to work).	

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F 157	Continued From page 7 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 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. Based on the above findings it was determined the facility's failure to ensure the Physician was notified related to a significant changes in a resident's physical condition and/or a need to alter treatment significantly was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 03/16/12 and determined to exist on 01/08/12. The facility was notified of the Immediate Jeopardy on 03/16/12. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/23/12 with the facility alleging removal of the Immediate Jeopardy on 03/18/12. Immediate Jeopardy was verified to be removed on 03/18/12. Additional findings during the Extended Survey revealed 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 edema in the lower extremities. On 03/12/12 the facility notified the Physician of the resident's lung congestion and persistent edema in the lower extremities and received a Physician's Order for a	F 157	4. As part of the facility's on-going Quality Assurance Program the Director of Nursing (Monday through Friday) and the charge nurse (Saturday and Sunday) will daily review all resident charts of those individuals with chronic conditions such as CHF, as well as those that who require Coumadin therapy to ensure proper care and services are being provided. These audits will continue for the next 90 days and then weekly thereafter. 5. 4/3/12	4/3/12

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F 157	Continued From page 8 chest x-ray to rule out CHF. However, 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. 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 incident. Based on the above findings it was determined the facility's failure to ensure the Physician and/or Responsible Party was notified related to a	F 157		

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F 157	Continued From page 9 significant change in resident's physical condition, a need to alter treatment significantly, and a resident's aggressive behavior towards other residents was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/28/12 and determined to exist on 12/31/11. The facility was notified of the Immediate Jeopardy on 03/28/12. A second acceptable credible AOC was received on 03/28/12 with the facility alleging removal of the Immediate Jeopardy on 03/29/12. Removal of Immediate Jeopardy was verified on 03/29/12 prior to exiting the facility on 03/29/12 with remaining non-compliance at 42 CFR 483.10 Resident Rights F-157 Notification of Change, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure appropriate notifications of residents' changes in conditions. In addition, Resident #2 had a red area noted on the bony prominence of the outer aspect of the left foot which was identified on 07/16/11 with treatment orders obtained. On 02/07/12 the wound changed to a deep purple color and increased in size; however, there was no documented evidence the Physician was notified. The findings include: Review of the facility's policy titled, "Changes in a Resident's Condition or Status", dated 01/09/03, revealed the facility must notify the resident's Physician when there was a significant change in the resident's physical, mental, or psychosocial status, or when there was a need to alter	F 157		

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F 157	Continued From page 10 treatment significantly. 1. Review of the medical record revealed Resident #1 was admitted to the facility on 08/05/10 with diagnoses which included Atrial Fribulation, Deep Vein Thrombosis, Chronic Renal Failure, and Colectomy for Cancer. Review of Physician's faxed orders, dated 01/06/12, revealed the Physician ordered Resident #1's Coumadin to be increased from 3 mg to 5 mg everyday and to have a PT/INR obtained on 01/11/12. Review of a Physician's Telephone Order, received at 5:20 PM on 01/08/12, revealed a Physician's order for Resident #1 to receive 750 mg Levaquin for an Upper Respiratory Infection everyday for five days. Review of a fax from the pharmacy, received at the facility at 8:01 PM on 01/08/12, revealed the pharmacy alerted the facility of a potential drug interaction between Coumadin and Levaquin and the need to monitor INR and watch for signs of bleeding. Review of a Quarterly Minimum Data Set, dated 01/09/12, revealed the facility assessed Resident #1 as being alert and oriented with a BIMS score of 15 out of 15, indicating the resident was cognitively intact. The facility assessed the resident as needing limited assistance with one person physical assist to use the toilet. A review of the laboratory report, dated 01/11/12, revealed Resident #1's PT was 30.3 seconds (normal: 9.5-11.8) and the INR was 2.9 (standard anticoagulant range: 2.0-3.0). The results were faxed to the Physician on 01/11/12. The Physician documented on the lab report 'NNO' (no new orders) and to repeat the PT/INR in one month.	F 157		

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F 157	Continued From page 11 Review of Physician's Orders, dated 01/27/12, revealed the Physician ordered for Resident #1 to receive Macrobid twice a day for 7 days related to the resident having a UTI (Urinary Tract Infection). Review of the Medication Administration Record (MAR) revealed Resident #1 received the Macrobid from 01/27/12 through 02/01/12. Interview with Consultant Pharmacist #1 and Consultant Pharmacist #2, on 03/20/12 at 10:00 AM, revealed all antibiotics could raise the INR of a resident on Coumadin therapy. Further interview revealed antibiotics, such as Levaquin Bactrim and Cipro, could raise the INR the most and it is recommended to have an INR obtained ten days after being off the antibiotic. Review of Nurses Notes (NN), dated 02/01/12 at 12:00 PM, revealed Resident #1 stated to the Director of Nursing (DON) that the he/she had passed some blood in his/her stool and the resident had flushed the commode before any staff could evaluate or see the stool. The DON documented she asked the resident if he/she wanted to go to the emergency room since the resident was on Coumadin, but the resident refused. The DON further documented she had explained to Resident #1 the Physician would be in that day and had stressed to the resident not to flush the commode until the nurse viewed any bowel movements. Interview with the DON and Licensed Practical Nurse (LPN) #1, on 03/16/12 at 4:00 PM, revealed they both were in the room when Resident #1 stated the he/she had passed some blood in the stool. The DON and LPN #1	F 157		

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F 157	Continued From page 12 indicated they did not call the resident's Physician because they knew the Physician would be in later that day because it was a Wednesday and he usually made rounds on Wednesday evenings. Interview with LPN #3, on 03/16/12 at 3:45 PM, revealed she had made rounds with Resident #1's Physician around 4:00 PM and the resident had told the doctor he/she had pain so the Physician ordered Tylenol. Further interview revealed she did not inform the Physician of the resident's earlier report of blood in the stool because she thought the DON had already notified the Physician.. Review of NNs, dated 02/01/12 at 10:00 PM, revealed Resident #1's color was pale. Further review of NNs revealed the resident had complained of blood in the stool earlier, but none had been noted thus far. Interview with LPN #5, on 03/16/12 at 7:00 PM, revealed she had worked the evening of 02/01/12 and noticed Resident #1 was "pretty pale" that night. Further interview revealed she did not notify the Physician about Resident #1's complaints of having blood in the stool because she thought since it was noted in shift change report that the Physician had been in earlier that evening that he was already aware of Resident #1 reporting blood in the stool. Review of NNs, dated 02/02/12 at 8:10 AM, revealed Resident #1 was weak, jaundiced, unresponsive at times and appeared to have blood in the urine and stool. Further review of the NNs revealed the Physician was notified and	F 157		

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F 157	Continued From page 13 ordered the resident be sent to the hospital for evaluation. Review of the hospital discharge summary, history and physical, and emergency room records, from 02/02/12 through 02/07/12 revealed Resident #1 had an INR of 8, a Hemoglobin of 5.8 grams per deciliter (normal range was 12.0-16.0 g/dL) and Hematocrit of 19.2 percent (normal range was 36.0-48.0 %). Further record review revealed Resident #1 was given 10 mg of Vitamin K by slow IV infusion in the emergency room, four (4) units of Red Blood Cells (RBC) upon admission to the hospital, and was diagnosed with Anemia from Acute Upper Gastrointestinal Bleed from Coumadin Toxicity. 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 was not alerted by the facility of the potential drug interaction between Levaquin and Coumadin on 01/08/12. Further interview revealed Resident #1 was alert and oriented and he would have expected when Resident #1 informed staff there was blood in the resident's stool, at 12:00 PM on 02/01/12, that he would have been notified immediately. He indicated if he had been made aware of Resident #1 having blood in the stool, he would have also ordered a PT/INR be obtained. 2. Record review revealed Resident #4 was admitted to the facility on 12/23/11 with diagnoses which included Dementia, Diastolic Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Hypertension. Review of the Weights and Vitals Summary	F 157		

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F 157	Continued From page 14 Report revealed a weight of 140.2 pounds on 03/05/12, a weight of 150.4 on 03/10/12, a 10.2 pound weight gain in five (5) days. Review of the Nutrition at Risk Progress Notes (NAR) dated 03/10/12 Completed by Licensed Practical Nurse (LPN) #1, revealed the resident had a weight gain of ten (10) pounds, edema, and the current Plan of Care would continue. Interview, on 03/19/12 at 3:30 PM, with the Director of Nursing (DON), revealed the Restorative Aides obtained weights and distributed copies of the weights to the nurse on duty, and also was to leave a copy of the weights in her office. She stated LPN #1 was responsible for completing the weekly NAR Notes for residents on weekly weights and if significant weight gains were noted, LPN #1 was to write a "nutritional note" indicating how much food/fluid the resident was consuming, and assess the resident as needed if weight gains were significant. Further interview revealed LPN #1 should have notified the Physician of the 10.2 pound weight gain on 03/10/12 and should have assessed the resident's lungs as well as checked for pitting edema of the lower extremities. Interview with LPN #1, on 03/19/12 at 4:00 PM, revealed it was her responsibility to review weights and monitor weight gain or loss of five percent (5%) or more. She stated if a weight gain was noted she would observe the resident for difficulty breathing and if difficulty was noted, she would auscultate the lungs and check for edema in the lower extremities. She further stated Resident #4 was not having shortness of breath on 03/10/12 and she did not feel the need to assess the resident. Continued interview	F 157		

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F 157	Continued From page 15 revealed she did not always communicate gains or losses to the nurses and was unsure of who was responsible for notifying the Physician of weight gains and losses. She stated, it would be important to notify the Physician of this resident's weight gain since the resident had a diagnosis of Congestive Heart Failure. Further interview, on 03/19/12 at 2:15 PM, with the DON and further review of the Weights and Vital Sign Summary revealed the resident's weight increased from 140.2 pounds on 03/05/12 to 150.4 pounds on 03/10/12, a 10.2 pound weight gain in five (5) days and then an additional 5.8 pound weight gain was noted on 03/19/12 when the resident's weight was recorded as 156.2 pounds, a total of 11.4% weight gain from 03/05/12 to 03/19/12; however, there was no documented evidence the Registered Dietician (RD) or Physician were notified of the significant weight gains. Interview, on 03/19/12 at 4:30 PM, with the Registered Dietician (RD), revealed she was to be notified of significant weight gains or losses. After reviewing the resident's weights, she stated she should have been notified of the weight gain on 01/16/12 and also of the weight gain on 03/10/12, but was unaware of these weight gains. She stated she was at the facility on 03/13/12; however, was not notified of the weight gain which was noted on 03/10/12. Continued interview revealed the 03/05/12 to 03/10/12 weights were in her mailbox and although she should have reviewed them already; she had not looked at them. She stated the DON and other nurses had not discussed Resident #4's weight gains with her and a ten (10) pound weight gain	F 157		

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F 157	Continued From page 16 was concerning. Continued interview revealed the weight gain would not be related to food/fluid consumption as the resident's intake for 02/20/12 until 02/29/12 was thirty-three percent (33%) and intake for 03/09/12 until 03/19/12 was forty-five percent (45%). Continued interview with the DON, on 03/22/12 at 2:30 PM, revealed residents with significant weight gains and losses were to be taken to the weekly Quality of Care Meeting and discussed by the interdisciplinary team; however, there was no meeting held the week of 03/11/12 due to the standard survey starting 03/13/12. Interview with the DON, on 03/19/12 at 2:15 PM, the DON stated she reviewed and recorded the weights into the computer each week after they were obtained. Continued interview revealed she entered the 03/10/12 weight into the computer on 03/12/12, when she noted the weight gain and brought it to staff's attention for the Physician to be notification. She further stated she could not recall which particular staff she informed. She stated LPN #4 called the Physician and a chest x-ray was ordered. Interview with LPN #4 on 03/22/12 at 9:00 AM revealed she had notified the Physician on 03/12/12 of the resident's pulmonary congestion and persistent pedal edema and a chest x-ray was ordered; however, she stated the she was unaware of any weight changes and had not notified the Physician of a weight gain on 03/12/12. Review of the Nurses Notes revealed documentation of vital signs and oxygen	F 157		

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F 157	Continued From page 17 saturations 03/10/12 through 03/19/12. The Notes 3/10/12 and 3/18/12 stated the resident's respirations were even and unlabored and the resident had edema in the lower extremities. Review of the Physician/)/GNP(Nurse Practitioner)/PA(Physician's Assistant) Communication and Progress Note, dated 03/19/12 at 11:00 AM, revealed Resident #4 was in a wheelchair holding her/his head in her/his hands and respirations were slightly labored. Further review, revealed the resident's oxygen saturation was eighty-eight percent (88%) and the Physician was notified. The next entry at 11:10 AM indicated the Physician returned the call and new Physician's Orders were noted. Review of the Physician's Orders dated 03/19/12 (no time documented) revealed orders for a urinalysis and culture and sensitivity, Chest X-Ray, Ceftin (antibiotic medication) five hundred milligrams (500 mg) twice a day for seven days. Further review revealed orders for oxygen at two liters per nasal cannula, and if oxygen saturation falls below ninety percent (90%) send to emergency room for evaluation. Review of the Nurses Notes, dated 03/19/12 at 3:00 PM and completed by LPN #3, revealed the resident was being transferred to the hospital emergency room for evaluation. The Note stated the resident's oxygen saturation was eighty-eight percent (88%) to eighty-nine percent (89%) with oxygen at two (2) liters per nasal cannula. Further review revealed the resident had bilateral lower extremity edema and respirations were slightly labored. Review of a subsequent Physician's Order dated	F 157		

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F 157	Continued From page 18 03/19/12 (no time documented) revealed orders to transfer the resident to the hospital emergency room for evaluation. Interview with LPN #3, on 03/19/12 at 3:05 PM, revealed she called the Physician at 11:00 AM because the resident's respirations were slightly labored and the resident's lower extremities were very swollen. She stated she received orders for a chest x-ray and oxygen at that time. She stated she was unaware of the resident having weight gain and therefore did not notify the Physician of weight gain. Continued interview revealed, later that day after lunch, the resident was still not feeling any better, and her/his respirations were labored and his/her oxygen saturation was only eighty-eight to eighty-nine percent (88-89%) with oxygen in place. She stated she called the Physician again and orders were received to transfer the resident to the emergency room. Review of the Emergency Department Report dated 03/19/12 at 3:51 PM, revealed the resident had decreased breath sounds, wheezing on expiration, and three plus (3+) pedal edema to the knees bilateral. Review of the hospital Chest X-Ray report, dated 03/19/12 at 3:58 PM, revealed; Impression: Cardiomegaly with changes of pulmonary edema and bilateral pleural effusions. Review of the Brain Natriuretic Peptide (BNP- a test used in diagnosis and assessment of severity of CHF) revealed a level of 1150 High (reference range of 0-99). Review of the Hospital Discharge Summary dated 03/22/12, revealed the Discharge Diagnoses included Diastolic Congestive Heart Failure with Exacerbation, and Chronic Obstructive Pulmonary Disease. The Summary stated the	F 157		

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F 157	Continued From page 19 resident had diuresed approximately five and a half (5.5) liters of fluid before discharge. Further review revealed the resident was being transferred back to the nursing home in improved condition, and was to be monitored on diuretics with doses adjusted as necessary based on fluid and clinical status. Review of a subsequent Hospital Emergency Department Notes revealed the resident arrived at the Hospital Emergency Room on 03/23/12 at 3:40 PM and was discharged at 03/23/12 at 6:03 PM with a diagnosis of a Urinary Tract Infection. Resident #4 expired at the facility on 03/24/12 at 4:00 AM. Interview, on 03/20/12 at 1:45 PM and on 03/27/12 at 5:00 PM, with Resident #4's Attending Physician/Medical Director, revealed the resident was diuresed at the hospital due to a diagnosis of Exacerbation of CHF. He stated he was unaware of the resident having weight gains in March 2012 and if he had known of the weight gains he would have checked a BNP lab test, to test for CHF and he would have started diuresing the resident with Lasix (diuretic medication) at the facility; 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 also stated he would have attempted other avenues of care and interventions if he had known of the weight gain earlier. He further stated, the weight gain played a vital role in the resident's CHF status. He continued to stated, the Chest X-Ray which was ordered on 03/12/12 was not significant for CHF, possibly because the fluid was building up peripherally at first, and there was not yet a build	F 157		

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F 157	Continued From page 20 up of pulmonary fluid. Continued interview, revealed the staff had made him aware of the resident being a little short of breath on 03/12/12; however, he did not remember hearing anything more "ominous". 3. Review of Resident #19's medical record revealed the resident was admitted to the facility on 08/02/10, with diagnoses which included Alcohol Dementia, Depression, Alzheimer's Disease, Schizophrenia and Positive Tuberculin Skin test. Review of Resident #19's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 01/15/12, revealed the facility assessed the resident to have no behavior symptoms exhibited. Review of the facility's "Resident Incident/Accident Report", dated 12/31/11 at 8:00 PM, revealed Resident #19 had an altercation with his/her roommate resulting in the roommate having facial redness. Further review revealed Resident #19 refused to go to the Emergency Room (ER) for an evaluation. Review of the facility's "Resident Incident/Accident Report", dated 03/04/12 at 5:15 PM, revealed Resident #19 had an altercation with Unsampled Resident D during meal service. Further review revealed Resident #19 slapped Unsampled Resident D across the face when he/she reached and grabbed Resident #19's hand. Review of the facility's "Resident Incident/Accident Report", dated 03/24/12 at 8:40 AM, revealed Resident #11 was waiting to enter the restroom when Resident #19 walked around Resident #11 and entered the restroom first.	F 157		

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F 157	Continued From page 21 Further review revealed both residents were separated as both residents drew back their fists to hit each other. Interview with the State Guardian, on 03/28/12 at 9:30 AM, revealed Resident #19 had been deemed incompetent by the court system. Further interview revealed he was not made aware of the incident on 03/04/12 and 03/27/12 until 03/27/12. The only incident he could recall was the incident on 12/31/11. 4. Review of the medical record revealed Resident #2 was admitted by the facility on 09/01/01 with diagnoses which included history of Cerebral Vasoular Accident, Alzheimer's Disease, Dementia, Depression, and Flaccid Hemiplegia Affecting Unspecified Side. Review of the resident's Annual Minimum Data Set (MDS) Assessment, dated 08/29/11, revealed the resident was at risk for pressure sores and had one Stage I pressure ulcer identified. Further review of the resident's Quarterly MDS Assessment, dated 02/27/12, revealed the resident had one Unstageable (deep tissue) identified. Record review for Resident #2 revealed Wound Care Summary documentation noted on 07/16/11 the resident developed a one (1) centimeter (cm) red area located on their outer right foot along the bony prominence near the base of the little toe. The resident had an order to apply Duoderm to the site every seven days. Review of subsequent Wound Care Summary weekly progress notes from 07/16/11 through 02/01/12 revealed the facility continued to describe the wound area as one (1) cm area of redness.	F 157		

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

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F 157	Continued From page 22 Continued review of the record revealed, the 02/07/12 progress note described a change in the characteristic of the wound site. The document described the site was now 0.6 cm by 1.8 cm, and was deep purple skin with smooth texture. There was no documentation in the record the Physician had been notified of the change identified on 02/07/12. The 03/07/12 weekly progress note described the site as being a deep purple black area. A Physician's order, for 03/07/12, changed wound care to wrap the Deep Tissue Injury (DTI) with Kling and change daily. The weekly nurse note on 03/11/12 identified the wound as a DTI. Observation of the site on 03/16/12 revealed a hard, brown scab which measured 0.8 by 1.2 cm. Interview about Resident #2's wound with the Licensed Practical Nurse (LPN) #4, on 03/16/12 at 2:40 PM, revealed the site began on 07/16/11 as a red area. The Physician ordered Duoderm to be applied every seven (7) days. On 02/07/12 the site changed, it was measured as 0.6 by 1.8 cm and it appeared to be more like a DTI. Further interview revealed she could not verify the Physician was notified about the change in the wound on 02/07/12. She did not get an order to change the wound care until 03/07/12, when the area around the wound began to form a dark crust. Interview with Resident #2's Physician/Medical Director, on 03/20/12 at 1:45 PM, revealed he can't say he was made aware of the change in Resident #2's wound on 02/07/12. He stated he may have changed the treatment by providing	F 157		

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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 157	Continued From page 23 nutritional supplements, such as Zinc and Vitamin C, if given the whole history at that time. It would be more about adding nutrients, then changing the dressing being applied. Interview with the Director of Nursing (DON) about Resident #2's wound, on 03/23/12, revealed LPN #4 told the DON she had "messed up" and could not remember talking to the Physician about Resident #2's wound change on 02/07/12. Further interview with the DON revealed the Physician should have been informed of the wound change in case he wanted to change the treatment. Review of the AOC revealed the following: 1. The clinical records of all residents receiving anticoagulant therapy were reviewed by the Licensed Nursing Home Administrator (LNHA) and the DON on 03/17/12, to ensure no negative outcomes as a result of their anticoagulant therapy and that all labs were obtained timely. 2. 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. 3. All residents' records with a diagnosis of CHF and other residents with other chronic conditions which would require ongoing monitoring were reviewed to ensure appropriate care was being provided and Physician notification of changes. 4. An in-services was conducted on 03/28/12 on	F 157		

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F 157	Continued From page 24 reviewing signs and symptoms of CHF and Physician notification of weight changes of 5% in thirty (30) days and 10% in one hundred eighty (180) days (gain or loss). 5. As part of the facility's ongoing QA program, the LNHA or the DON, will audit one hundred (100) percent of resident charts that are currently receiving Coumadin therapy daily for the next thirty (30) days, and then weekly thereafter, to provide a double check to ensure proper assessment of resident concerns, documentation which details care provided to each resident and that meets current professional standards, and physician notification. Any issues that are identified will be reviewed by the LNHA and the Medical Director, and in turn will develop an action plan for any identified issue noted above. 6. As part of the facility's on-going QA program the LNHA, DON and charge Nurse will daily review all residents' charts who have a diagnosis of CHF to ensure proper care and services and Physician notification of changes in conditions. The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows: *Interview with the DON, on 03/27/12 at 2:55 PM, revealed Administration called every staff member to come for the in-service on 03/17/12 and all licensed staff attended the in-service with the exception of one (1) License Practical Nurse (LPN) and she was in-serviced prior to her working her next shift on the 03/23/12. Further interview revealed, the DON was on duty when this LPN came to work and performed return	F 157		

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F 157	Continued From page 25 demonstration prior to her assignment. *Interview with the DON, on 03/27/12 at 3:00 PM, revealed on 03/17/12 the medical chart for all residents receiving anticoagulant therapy was reviewed to ensure there was no negative outcomes as a result of their anticoagulant therapy and that all labs were obtained timely, and after reviewing all the resident medical records, it was determined there was no negative outcome. Continued interview revealed the medical records of all residents with CHF or other conditions which require ongoing assessment and monitoring were reviewed to ensure proper Physician notification. *Interview with the DON, on 03/27/12 at 3:00 PM, revealed all licensed staff was in-serviced on reviewing 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", revealed all licensed staff attended the in-service. Interview with LPN #2, on 03/27/12 at 10:00 AM, interview with LPN #4, on 03/27/12 at 11:15 AM, interview with LPN #1, on 03/27/12 at 2:00 PM, interview with LPN #6, on 03/27/12 at 3:30 PM, interview with LPN #3, on 03/27/12 at 3:45 PM, revealed they had attended the in-service conducted on 03/17/12 at 1:00 PM and were knowledgeable of the information covered in the in-service. *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	F 157		

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F 157	Continued From page 26 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. *Interview with the LNHA, on 03/29/12 at 10:45 AM, revealed she conducted an in-service, titled "Resident's 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. *Review of the sign in sheet for the in-service revealed all staff; with the exception of LPN #7 was in attendance. Interview with LPN #2, on 03/29/12 at 9:00 AM, interview with LPN #4, on 03/29/12 at 9:15 AM, interview with LPN #1, on 03/29/12 at 9:20 AM, interview with LPN #6, on 03/29/12 at 9:30 AM, interview with MDS Nurse #3, on 03/29/12 at 9:30 AM, interview with LPN #3, on 03/29/12 at 9:40 AM, interview with LPN #5, on 03/29/12 at 9:45 AM, interview with LPN #9, on 03/29/12 at 9:50 AM, interview with LPN #8, on 03/29/12 at 10:00 AM, revealed they had attended the in-service conducted on 03/28/12 at 5:00 PM and were knowledgeable of the information covered in the in-service. Interview with LPN #7, on 03/29/12 at 10:05 AM, revealed	F 157		

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

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F 157	Continued From page 27 the LNHA had contacted her and informed her that before she was able to return to work she would have to attend an in-service related to residents with CHF. *Review of the audit titled, "Review of Residents with CHF" on 03/29/12, revealed daily audit of the residents' charts for residents 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. She further stated these audits would be reviewed daily (Monday through Friday) in the morning meetings and then every month in the QA committee meetings. Continued interview revealed Administration had participated in the creation of the audit forms and the in-services, and assured staff was knowledgeable on all information covered in the in-service.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to promote care for	F 241	F241 It is and was on the day of survey the policy of Hilltop Lodge to promote care in a manner and in an environment that enhances each resident's dignity and respect. 1. Resident#6 continues to require a Foley Catheter. The Foley is being covered with a dignity bag.	

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F 241	Continued From page 28 residents in a manner and in an environment that maintained or enhanced each residents' dignity and respect in full recognition of his or her individuality as evidenced by observation of one (1) of twenty-four (24) sampled residents (Resident #6) with a catheter urinary catheter bag not in a dignity bag and easily viewed from the hallway. The findings include: Review of the facility's policy: Resident Dignity and Respect, dated 01/09/03, revealed it was the policy of this facility to that all residents will be treated with kindness, dignity, and respect. Further review revealed residents shall be treated in a manner that maintains the privacy of their bodies. Record review for Resident #6 revealed the facility admitted the resident on 02/24/12 with diagnoses which included Cerebral Vascular Accident, Urinary Retention, and Neurogenic Bladder and Hypertrophy Prostate. The resident had an order, dated 02/24/12, for a Foley Urinary Catheter. The care plan included an intervention to position the bag away from the entrance room door. Observations, on 03/13/12 at 7:02 PM, on 03/14/12 at 11:50 AM and on 03/14/12 at 4:45 PM, revealed the urinary drainage collection bag was visible from the hallway and not contained in a dignity bag. Interview with Certified Nursing Assistant (CNA) #1, on 03/20/12 at 11:00 AM, revealed urinary catheter bags are supposed to covered. It did not	F 241	2. All residents with Foley Catheters have been monitored to ensure that dignity and privacy have been maintained. 3. An in-service was conducted on 4/20/12 by the Executive Director with all staff (license and unlicensed) in attendance to review privacy and dignity concerns. 4. As part of the facility's ongoing Quality Assurance daily the Director of Nursing will monitor resident care to ensure care is provided which maintains or enhances each resident's dignity and respect. This audit will continue for the next six months. 5. 4/21/12	4/21/12

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F 241	Continued From page 29 look right seeing their urine. Further interview revealed Resident #6's urinary catheter bag had not always been covered. CNA #1 further stated all aides were supposed to make sure the bag was covered. Interview with Licensed Practical Nurse (LPN) #3, on 03/20/12 at 2:30 AM, revealed you should not have been able to view Resident #6's urinary catheter bag from the hallway. That would be a dignity issue. It was the nurses' responsibility to ensure the urinary catheter bags were not observable. Interview with the Director of Nursing (DON), on 03/22/12 at 12:10 PM, revealed the Foley Catheter urinary collection bag should have been enclosed and not visible. It was a dignity issue for residents. She stated the aides should know it, but the nurses should have been monitoring. She would expect staff to know to put the bag into a privacy bag or they could put it on the other side of the bed or if in a wheelchair it could be placed on the other side so it was not visible from the door.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F279 It is and was on the day of survey the policy of Hilltop Lodge to use resident assessments to develop, review and revise the resident's comprehensive plan of care. Both residents remain in the facility and their current PT/INR remains within sub-therapeutic ranges.	

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F 279	Continued From page 30 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop a Comprehensive Plan of Care for each resident that included measurable objectives and individual interventions to meet the residents medical, nursing, mental and psychosocial needs for two (2) of twenty-four (24) sampled residents (Residents #7 and #12). Residents #7 and #12 both received anticoagulant therapy (Coumadin). Review of Resident #7's and Resident #12's Comprehensive Plans of Care revealed the facility failed to develop Plans of Care with interventions to address the use of anticoagulant therapy (Coumadin). The findings include: Review the facility's policy titled, "Care Plans Comprehensive", dated 01/09/03, revealed it was the policy of this facility to develop a	F 279	1. Resident #7 and #12 remain in the facility. PT/INR levels were completed on resident #7 on 4/13/12 with results of PT 33.2 and INR 3.2, a physician's order followed for resident #7 to be redrawn in one week. PT/INR levels were completed on resident #12 on 4/10/12, the PT was 22.6 and INR was 2.2, the physician then ordered for this to be redrawn in one month. Resident #7 and #12's plans of care were revised and updated to reflect the above; this was done by the assessment nurse. 2. All residents who receive Coumadin are being monitored by the licensed staff daily for signs and symptoms of abnormal bleeding for the next ninety days and then weekly thereafter. All residents care plans were updated and revised by MDS assessment nurses. The newly revised care plans are in place. Daily the Director of Nursing is ensuring changes in resident care is being care planned by reviewing report, checking physician orders and daily rounds. 3. An in-service was conducted by Stacey Richardson, RN, BSN,	

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F 279	Continued From page 31 comprehensive care plan for each resident that included measurable objectives to meet the resident's medical, nursing, and psychological needs. Further review revealed the comprehensive care plan should be designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, and reflect treatment goals and objectives in measurable outcomes. 1. Review of the medical record revealed the facility re-admitted Resident #7, on 10/04/11, with diagnoses which included Anemia, Seizures, and Atrial Fibulation. A review of Laboratory Reports, Physician's Orders, and Nurse's Notes from 10/04/11 through 03/17/12 revealed Resident #7 received anticoagulant therapy (Coumadin). Further record review revealed the resident's Coumadin dosage and Prothrombin (PT) and International Normalized Ratio (INR) laboratory results fluctuated and on 02/22/12 Resident #7's PT was 64.6 and the INR was 6.4 (critical high). Review of Resident #7's Comprehensive Plan of Care, dated 12/02/11, revealed there was no evidence a plan of care was developed to address the use and the required monitoring of anticoagulant therapy (Coumadin). Interview with the Director of Nursing (DON), on 03/22/12 at 2:55 PM, revealed a plan of care should have been developed to ensure monitoring of the PT/INR during Coumadin therapy, especially for Resident #7 who had a history of fluctuating PT/INR's and a history of having a critical high INR. 2. Record review revealed the facility originally	F 279	LNHA on 3/17/12 reviewing physician notification, anticoagulant therapy, and documentation requirements. An additional inservice was conducted by Stacey Richardson, RN, BSN, LNHA on 3/28/12 related to care plan development and updates. Those in attendance were Carrie Sparks, LPN, assessment nurse. 4. As part of the facility's ongoing Quality Assurance program the Director of Nursing will monitor all residents receiving Coumadin therapy at least monthly for the next six months to ensure that the residents' comprehensive plan of care is being reviewed and/or revised appropriately. Weekly the Director of Nursing will monitor 10% of the care plans to ensure all problems are identified and addressed. This will continue for the next six months. 5. 3/30/12	3/30/12

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F 279	Continued From page 32 admitted Resident #12 on 11/07/11 with diagnoses which included Transient Ischemic Attack (TIA-similar in symptoms to transient mini strokes), Atrial Fibrillation, Hyperlipidemia, Parkinson's Disease and Alzheimer's. Review of Resident #12's Comprehensive Plan of Care, dated 11/22/11, revealed no documented evidence there was a plan of care in place to address the use and monitoring of anticoagulant therapy, such as Coumadin. Interview, on 03/23/12 at 11:15 AM, with LPN #3 revealed a Coumadin Log sheet was maintained on Resident #12 which listed the lab values and the next scheduled PT/INR however, the facility had failed to develop a care plan with specific interventions such as monitoring Resident #12 for signs and symptoms of bleeding related to anticoagulant therapy. Interview with the DON, on 03/23/12 at 10:10 AM, revealed a plan of care should have been developed to ensure monitoring of Resident #12, who was on anticoagulant therapy. Interventions should have included review of the medication list for adverse reactions including caution with medications including aspirin or antibiotics such as Levaquin. She stated it would be important to have a care plan for anticoagulant therapy for Resident #12, who was noted to have a one time dose of the antibiotic Levaquin and multiple dosing changes related to the fluctuation in the PT/INR's including a history of a critical high INR.	F 279		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	F280 It is and was on the days of survey the policy of Hilltop Lodge to ensure care plans are developed within	

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F 280	Continued From page 33 Incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to have an effective system to ensure Comprehensive Care Plans were revised with interventional strategies for three (3) of twenty-four (24) sampled residents (Residents #19, #1, and #4). Resident #19 had a history of showing aggressive behavior towards other residents. The facility failed to ensure adequate supervision to ensure each resident was protected from abuse as evidenced by the failure to review and revise the Plan of Care for a resident with a personal history of being at risk of abusing other residents. The	F 280	seven days after completion of the comprehensive assessment and care plans are periodically reviewed and revised by a team of qualified persons after each assessment. 1. Resident #19 was transferred on 3/28/12 and resident #1 remains in the facility. Resident #1's care plan was revised per the MDS assessment nurse on 4/9/12. Resident #4 returned to the facility on 3/22/12 and was again hospitalized on 3/23/12 and died on 3/24/12, therefore her care plan was not revised. 2. All resident care plans were revised on 4/9/12 by the MDS/Care Plan nurse. 3. The MDS/Care Plan Nurse will daily (Monday through Friday) review telephone orders and shift report to ensure care plans are updated as resident care needs change. Saturday and Sunday's orders and shift report will be reviewed on Monday. 4. As part of the facility's ongoing Quality Assurance Program the	

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	185307		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

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F 280	Continued From page 34 facility also failed to develop interventional strategies in preventing occurrences and monitoring changes in Resident #19's aggressive behavior and failed to reassess current interventions for appropriateness on a regular basis. Resident #19 exhibited three (3) different episodes of aggressive behaviors with two (2) of the incidents resulting in Resident #19 slapping one (1) unsampled and one (1) sampled resident (Resident #11) in the face. Resident #1 sustained a 5.8 pound weight loss while in the hospital from 02/02/12 through 02/07/12. The facility failed to revise the Comprehensive Plan of Care for the actual weight loss to include new interventions to prevent further weight loss. The facility failed to revise Resident #4's Comprehensive Plan of Care to include a psychotropic care plan for the medication Haldol (antipsychotic medication used to treat nervous, emotional and mental conditions). The facility's failure to ensure the Comprehensive Plans of Care were reviewed and revised to address aggressive behaviors to protect residents placed residents at risk for serious injury, harm, impairment or death. The facility was notified of the Immediate Jeopardy on 03/28/12. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/28/12 with the facility alleging removal of the Immediate Jeopardy on 03/29/12. Immediate Jeopardy was verified to be removed on 03/29/12 prior to exiting with the facility on 03/29/12 with remaining non-compliance at 42 CFR 483.20 Resident	F 280	Director of Nursing will weekly audit 10% of the residents' care plans to ensure they are being revised to reflect the resident's current care needs. This audit will continue for the next six months. 5. 4/10/12	4/10/12

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

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F 280	Continued From page 35 Assessment, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure care plans are reviewed and revised. The findings include: Review of the facility's policy titled, "Care Plan-Goals and Objectives", dated 01/09/03, revealed care plans incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Goals and objectives were resident oriented, behaviorally stated, measurable and within a specific time frame. The policy further stated the information was entered on the resident's care plan so that all disciplines had access to the information. Continued review of the facility policy revealed goals and objectives were reviewed and/or revised when there had been a significant change in the resident's condition, when the resident had been re-admitted to the facility from a hospital stay and/or at a minimum, quarterly. Review of the facility's policy titled, "Care Plan-Using the Plan", dated 01/09/03, revealed care plans were used in developing the resident's daily care routines. Further review of the policy revealed, changes in the resident's condition must be reported to the RN assessment coordinator so that a review of the resident's assessment and care plan could be made and daily care and documentation must be consistent with the resident's care plan. 1. Review of Resident #19's medical record revealed the resident was admitted to the facility	F 280		

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F 280	Continued From page 36 on 08/02/10, with diagnoses which included Alcohol Dementia, Depression, Alzheimer's Disease, Schizophrenia. Review of Resident #19's Comprehensive Care Plan (CCP), dated 07/25/11, revealed a problem of the resident having a potential for violence related to behavioral problems in the past, auditory hallucinations, delusions, repeating questions for pop and cigarettes secondary to Dementia, Alzheimer's and Schizophrenia. Further review of the Care plan revealed interventions which included: reality orientation, use calm unhurried approach, allow to express feelings in non-violent ways, remove items from the environment that could be used to harm self or others, give medication as ordered, and call by name each time approached. Review of the facility's, "Resident Incident/Accident Report", dated 12/31/11 at 8:00 PM, revealed Resident #19 had an altercation with his/her roommate (Resident #5), slapped his/her roommate in the face, resulting in the Resident #5 having facial redness. Review of the Comprehensive Care Plan (CCP) revealed no documented evidence of new interventions to address Resident #19's behavior following the 12/31/11 incident. Interview with the Director of Nursing (DON), on 03/27/12 at 2:55 PM, revealed she was unsure if the Plan of Care was updated at the time of the 12/31/11 incident or not. Further interview revealed, the facility was aware of prior behaviors while Resident #19 was at other facilities. Further interview confirmed the Plan of Care was not updated and no new interventions were put into	F 280		

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	185307	A. BUILDING B. WING	03/29/2012

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

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F 280	Continued From page 37 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 to include closer supervision after the 12/31/11 incident. Review of the facility's "Resident Incident/Accident Report", dated 03/04/12 at 5:15 PM; revealed Resident #19 had an altercation with Unsampled Resident D during meal service. Further review revealed Resident #19 slapped Unsampled Resident D across the face when he/she reached and grabbed Resident #19's hand. Interview with the ED, on 03/27/12 at 8:30 AM, regarding the 03/04/12 incident revealed she must have been aware of the incident because she had signed the report. Further interview revealed, Resident #19 had no intent to harm anyone. Interview with the Director of Nursing (DON), on 03/27/12 at 2:55 PM, revealed she was responsible for the Minimum Data Set (MDS) Assessments and completion of the CPC but she was unsure if the CPC was updated at the time of the incident or not. Review of the Care Plan revealed on 03/04/12 an intervention was added to separate Resident #19 and Unsampled Resident D and place Resident #19 on every fifteen (15) minute monitoring. Review of the CPC with the DON, on 03/27/12 at 2:55 PM, revealed the intervention put into place on 03/04/12 was not a clear and concise intervention and it did not indicate how long nursing staff would be monitoring Resident #19. Also, the DON confirmed the other interventions	F 280		

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F 280	Continued From page 38 should have been reviewed and/or revised for appropriateness at the time. Further review of the CPC, revealed the goal to include, "will be free from injury, harm to self or others". The DON recognized from the goal that Resident #19 was a risk to harm him/herself and/or other residents. The DON could not identify as to why the interventions were not updated and/or revised. Review of the facility's "Resident Incident/Accident Report", dated 03/24/12 at 8:40 AM, revealed Resident #11 was waiting to enter the restroom when Resident #19 walked around Resident #11 and entered the restroom first. Further review revealed both residents were separated as both residents drew back their fists to hit each other. Further review of the Plan of Care, revealed there was no documented evidence of any new interventions to address Resident #19's behavior following the 03/24/12 incident. Interview with the DON, on 03/27/12 at 2:55 PM, revealed Resident #19's CPC should have been reviewed and revised for appropriateness after each behavioral episode. (Refer to F-323) 2. Review of the medical record revealed the facility admitted Resident #1 on 08/05/10 with diagnoses which included Atrial Fibrillation, Deep Vein Thrombosis, Chronic Renal Failure, and Colectomy for Cancer. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 01/09/12, revealed the facility assessed the resident to need oversight with eating and set-up help only at meals.	F 280		

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F 280	Continued From page 39 Review of the Comprehensive Plan of Care, dated 07/18/12, revealed the facility had developed a plan of care documenting the resident had potential for weight loss and poor nutritional status secondary to chronic diarrhea and history of colon cancer. Review of Resident #1's weekly Weight Sheet revealed Resident #1 weighed 124.2 pounds on 01/28/12. Review of facility Nurse's Notes revealed Resident #1 was admitted to the hospital from 02/02/12 through 02/07/12 related to Coumadin Toxicity. A readmission weight to the facility, obtained on 02/08/12, revealed Resident #1 weighed 118.4 pounds and had sustained a 5.8 pound/4.6 percent weight loss. Continued review of the Comprehensive Care Plan revealed no documented evidence the CPC was revised to include the weight loss with additional interventions to address the weight loss and prevent further weight loss. Record review revealed the next weight was not obtained until 02/18/12, ten days later, which revealed Resident #1 weighed 115.4 pounds and had sustained an additional 3 pound/2.5 percent weight loss for a total of 8.8 pounds/7 percent weight loss in less than one month. Continued review of the Comprehensive Care Plan revealed no documented evidence the CPCP was revised to include the weight loss with additional interventions to address the weight loss and prevent further weight loss. Interview with the DON/MDS Coordinator, on 03/14/12 at 10:15 AM and 03/21/12 at 4:15 PM,	F 280		

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F 280	Continued From page 40 revealed she was responsible for revising the plan of care and she should have revised Resident #1's plan of care related to actual weight loss when the resident returned from the hospital with a 5.8 pound/4.6 percent weight loss with new interventions to prevent further weight loss. (Refer to F-325) 3. Review of Resident #4's medical record revealed diagnoses which included Dementia and Anxiety Disorder. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/30/11, revealed the facility assessed the resident as having both short and long term memory loss and as having moderate impairment in cognitive skills for decision making. Further review revealed the resident was receiving a anti-psychotic and anti-anxiety medication. Review of the Care Area Assessment Summary (CAAS), dated 01/02/12, revealed the resident received medications for anxiety due to having periods of anxiety attacks and received Valium (benzodiazepine used to treat anxiety disorders). Review of the Comprehensive Plan of Care (CPC), dated 01/03/12, revealed the resident was receiving Valium related to anxiety disorder with interventions to observe for anti-anxiety medication side effects. Review of the Physician's Order Form, dated 03/12, revealed orders for Haldol 0.5 milligrams twice daily every six (6) hours as needed for increased agitation/behaviors. However, there was no current order for Valium. Continued review of the CPC for Resident #4	F 280		

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F 280	Continued From page 41 revealed the care plan still reflected the use of Valium and failed to address the use of Haldol and interventions related to the medication. Interview on 03/19/12 at 3:00 PM, with the Director of Nursing (DON), revealed she was responsible for revising Care Plans and should have revised Resident #4's Care Plan when the Valium was discontinued and the Haldol was ordered. Interview with the Administrator, on 03/27/12 at 3:00 PM, revealed she was not aware the CPC's were not updated and/or revised. Further interview revealed, the CPC's should be updated daily, Monday through Friday based on morning meetings. Continued interview revealed, the facility had a process failure with updating and revising CPC's. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/28/12 with the facility alleging removal of the Immediate Jeopardy on 03/29/12. Immediate Jeopardy was verified to be removed on 03/29/12. Review of the AOC revealed the following: 1. On 03/27/12, the Resident #19 was sent out for a psychiatric evaluation at approximately 8:30 PM, and was sent back to the facility on 03/28/12 at 3:30 AM , after the psychiatric unit refused to admit the resident. On 03/28/12, one (1) on one (1) supervision was initiated upon the resident's return to the facility, the resident's guardian was notified to inquire about placement at another facility and agreed, and the resident was transferred at 9:00 AM on 03/28/12.	F 280		

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F 280	Continued From page 42 2. All residents with behaviors were reviewed by the Social Service Director (SSD) and Licensed Nursing Home Administrator (LNHA), and behavior monitoring logs were put into place for each individual and were to be completed as directed by licensed staff only. The Social Service Director communicated with the MDS Coordinator to update the care plan interventions if behaviors were exhibited. 3. On 03/28/12, an in-service was conducted with all licensed nursing staff with the exception of two LPN's which would be in-serviced before returning to work. The in-service was related to the behavior monitoring program, tracking of behaviors and care plan assessments and updates. Information covered in the in-service included what to do if a resident to resident altercation occurred, licensed staff was to initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors were exhibited one (1) on one (1) supervision and immediate psychiatric evaluation would 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. The licensed staff was also instructed to review or revise the plan of care when there had been a significant change in a resident's condition including identifying problems, contributing factors and risk factors then revise the the Comprehensive Care Plan. 4. As part of the QA program, the SSD should daily (Monday through Friday) review the behavior monitoring/tracking log to ensure that they were being completed properly, the	F 280		

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F 280	Continued From page 43 administrative staff member who was 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 behaviors were exhibited. The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows: *Interview with the SSD, on 03/29/12 at 10:30 AM, revealed she had reviewed all the residents' medical records who had behaviors to ensure a Behavior Monitoring Log was in place for each individual resident and was completed as directed by the licensed staff and communicated with the MDS Coordinator to update the care plan interventions. *A review of the record for all residents that were identified as exhibiting behaviors were reviewed and it was verified that the Care Plans were revised to include interventions related to behaviors. *Interview with the LNHA, on 03/29/12 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 related to revising the Care Plan any time a resident exhibited behaviors. *Review of the in-service revealed, staff was instructed on how to fill out the behavior	F 280		

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F 280	Continued From page 44 monitoring program and tracking of behaviors form. If a resident to resident altercation occurred, licensed staff was in-serviced to initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors were exhibited one (1) on one (1) supervision and immediate psychiatric evaluation would take place, and to immediately notify the Executive Director (ED) or the LNHA if resident to resident physical altercations took place to ensure resident safety. *Review of the sign in sheet for the in-service revealed all staff; with the exception of LPN #7, was in attendance. Interview with LPN #2, on 03/29/12 at 9:00 AM, interview with LPN #4, on 03/29/12 at 9:15 AM, interview with LPN #1, on 03/29/12 at 9:20 AM, interview with MDS Nurse #3, on 03/29/12 at 9:30 AM, interview with LPN #6, on 03/29/12 at 9:30 AM, interview with LPN #3, on 03/29/12 at 9:40 AM, interview with LPN #5, on 03/29/12 at 9:45 AM, interview with LPN #9, on 03/29/12 at 9:50 AM, interview with LPN #8, on 03/29/12 at 10:00 AM, revealed they had attended the in-service conducted on 03/28/12 at 5:00 PM and were knowledgeable of the information covered in the in-service. Interview with LPN #7, on 03/29/12 at 10:05 AM, revealed the LNHA had contacted her and informed her that before she was able to return to work she would have to attend an in-service related to residents with behaviors *Review of the monitoring tool titled, "Behavior Monitoring/Tracking Log" on 03/29/12, revealed daily audits of the record for residents with behaviors was conducted on 03/28/12, and was ongoing.	F 280		

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F 280	Continued From page 45 *Interview with the 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 was to review on Saturday and Sunday. She further stated these audits would be reviewed weekly in the morning meetings to ensure Comprehensive Care Plans were revised and then every month in the QA committee meetings. *Interview with Administration revealed they had participated in the creation of the audit forms and the in-services, and assured staff was knowledgeable on all information covered in the in-service and all staff was knowledgeable of the importance in revising the Care Plans.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide services that met professional standards of quality by failing to ensure Physician's orders were followed for one (1) of twenty-four (24) sampled residents (Residents #13). The facility failed to ensure Physician's orders were followed for Resident #13. A Physician's order dated, 03/03/12, to change the Coumadin (anticoagulant medication) dose to five (5) milligrams (mg) everyday was marked on the Medication Administration Record (MAR) to be	F 281	F281 It is and was on the day of survey the policy of Hilltop Lodge to provide or arrange services which meets professional standards of quality. 1. Resident #13 remains in the facility with no ill effects. 2. All resident records were audited on 3/28/12 by licensed staff to ensure professional standards of quality are being followed. All residents on Coumadin therapy are being monitored daily by the licensed staff to ensure proper care is being provided.	

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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 281	Continued From page 46 started on 03/05/12, and as a result the resident received 4 mg of Coumadin instead of 5 mg on 03/04/12. 1. Review of Resident #13's clinical record revealed the facility admitted the resident on 09/12/08 with diagnoses which included a History of a Deep Vein Thrombosis 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 for decision making. Review of the Physician's orders, dated 03/03/12, revealed orders to change the Coumadin (anticoagulant medication, blood thinner) dose to 5 mg everyday. Review of the MAR, dated 03/2012, revealed an arrow was marked on the MAR for the dosage of 5 mg to start on 03/05/12. Further review revealed the MAR was initialed indicating the resident received 4 mg of Coumadin on 03/04/12 instead of the 5 mg which was ordered. Interview, on 03/23/12 at 3:50 PM, with the Director of Nursing (DON), revealed the Coumadin medication was transcribed incorrectly on the 03/2012 MAR by a nurse who no longer worked at the facility. She stated the 5 mg of Coumadin should have been started on 03/04/12 instead of 03/05/12 as per the Physician's orders.	F 281	3. An in-service was conducted by Stacy Richardson, RN, BSN, LNHA on 3/17/12 reviewing proper assessment, physician orders and notification. All licensed staff were present for the inservice. 4. As part of the facility's ongoing Quality Assurance Program the Director of Nursing will monitor all residents receiving Coumadin therapy daily for the next ninety days, and then weekly thereafter for the next six months to ensure professional standards of care are being provided. Monitoring will include review of labs, signs and symptoms of abnormal bleeding and any ordered for antibiotic therapy. Monthly the Director of Nursing will audit 10% of the charts to ensure professional standards are met and MD orders are being followed. This audit will continue for the next six months. 5. 3/30/12	3/30/12
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F282 It is and was on the days of survey the policy of Hilltop Lodge to provide or arrange services that are	

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F 282	Continued From page 47 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies, it was determined the facility failed to have a system in place to ensure services were provided in accordance with each resident's written plan of care for two (2) of twenty-four (24) sampled residents (Resident #1 and #4). 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 when, on 02/01/12 at 12:00 PM, Resident #1 reported to the Director of Nursing (DON) he/she passed some blood in his/her stool. There was no documented evidence the facility notified the Physician of the Resident #1's report of blood in the stool. On the next morning, 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 sent to the hospital via ambulance required 10 mg of Vitamin K by slow intravenous (IV) infusion in the emergency room, given four (4) units of Red Blood Cells (RBC) upon admission to the hospital and was diagnosed with Anemia from Acute Upper Gastrointestinal Bleed due to Coumadin Toxicity.	F 282	provided to qualified persons in accordance with each resident's written plan of care. 1. Resident #1 remains in the facility with care and services being provided according to her current plan of care. Resident #4 returned to the facility following the hospitalization of 3/19/12. Following subsequent hospitalizations the resident has since died. 2. All resident care plans have been revised and services are being provided by qualified persons in accordance to each resident's written plan of care. 3. An inservice with the MDS/Care Plan nurse was conducted by the Administrator on 3/28/12 to ensure appropriate care planning. An inservice was conducted with all licensed staff to discuss implementation of care plans by Stacey Richardson, LNHA, on 3/28/12. 4. Weekly during the facility's Quality of Care meeting specific care areas will be reviewed (weights,	

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F 282	Continued From page 48 (Refer to F-329) The facility developed a Comprehensive Plan of Care for Resident #4 related to the resident's diagnosis of Congestive Heart Failure (CHF) with interventions in place to observe for weight gain. However, there was no documented evidence Resident #4's weight gains were being monitored or acted upon although the resident was exhibiting signs and symptoms of CHF such as edema in the lower extremities and lung congestion. The resident had a weight gain of 10.2 pounds from 03/05/12 through 03/10/12 (five days). On 03/19/12 the facility assessed the resident to have a further weight gain of 5.8 pounds from 03/10/12 through 03/19/12 (nine days). There was no documented evidence the care plan was followed related to monitoring Resident #4's further weight gain although the resident had a total weight gain of sixteen (16) pounds from 03/05/12 through 03/19/12. On 03/19/12 the resident became short of breath with labored respirations and was transferred to the hospital where she/he was diagnosed with Exacerbation of Congestive Heart Failure with Pulmonary Edema and Hypoxia. Resident #4 expired on 03/24/12. (Refer to F-309). The facility's failure to ensure services were provide based on the residents' Comprehensive Plans of Care placed residents at risk for serious injury, harm, impairment or death. The facility was notified of the Immediate Jeopardy related to monitoring of Resident #1 on 03/23/12. The facility was notified of the Immediate Jeopardy	F 282	falls, behaviors, edema, restraints, etc.) to ensure care is being provided in accordance with each resident's written plan of care. Weekly the Director of Nursing is auditing 10% of care plans to ensure they are updated and implemented this will continue for the next six months. This audit will include physician orders to ensure staff are following orders as prescribed by the physician. This process will continue for the next six months. 5. 3/30/12	3/30/12

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F 282	Continued From page 49 related to monitoring of Resident #4 on 03/28/12. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/23/12 with the facility alleging removal of the Immediate Jeopardy on 03/18/12 related to Resident #1. Immediate Jeopardy was verified to be removed on 03/18/12 as alleged prior to exit. A second acceptable credible AOC was provided on 03/28/12 with the facility alleging removal of the Immediate Jeopardy on 03/29/12 related to Resident #4. Immediate Jeopardy was verified to be removed on 03/29/12 as alleged prior to exiting with the facility on 03/29/12 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure appropriate care and services are provided to residents in accordance with each resident's Comprehensive Plan of Care. The findings include: Review of the facility's policy titled, "Comprehensive Care Plans", dated 01/09/03, revealed a interdisciplinary team was to develop and maintain a comprehensive care plan for each resident. Further review revealed the comprehensive care plan was designed to prevent decline in the resident's functional status and/or functional levels. 1. Review of the medical record revealed the facility admitted Resident #1 on 08/05/10 with diagnoses which included Atrial Fibulation, Deep Vein Thrombosis, Chronic Renal Failure, and	F 282		

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F 282	Continued From page 50 Colectomy for Cancer. Review of Physician's Orders and the Medication Administration Records from 08/05/10 through 02/01/12, revealed Resident #1 was receiving Coumadin (anticoagulant) therapy due to the diagnoses of Atrial Fibulation. Review of the Comprehensive Plan of Care, dated 01/10/12, revealed a plan of care was developed related to the resident receiving Coumadin therapy with interventions to report increased weakness, bleeding gums, and blood in stool or urine. Review of a Quarterly Minimum Data Set, dated 01/09/12, revealed the facility assessed Resident #1 as being alert and oriented with a BIMS score of 15 out of 15, indicating the resident was cognitively intact. The facility assessed the resident as needing limited assistance with one person physical assist to use the toilet. Review of Nurses Notes (NN), dated 02/01/12 at 12:00 PM, revealed Resident #1 stated to the Director of Nursing (DON) that he/she had passed some blood in his/her stool. However, there was no documented evidence this was reported to the resident's Physician, per the Plan of Care. Interview with the DON and Licensed Practical Nurse (LPN) #1, on 03/16/12 at 4:00 PM, revealed they both were in the room when Resident #1 stated the he/she had passed some blood in the stool. The DON and LPN #1 indicated they did not call the resident's Physician, per the Comprehensive Care Plan, because they knew the Physician would be in later that day. Further interview with the DON revealed she did not report the bleeding, per the plan of care, because she did not actually see the	F 282		

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F 282	Continued From page 51 blood because Resident #1 had already flushed the commode. Interview with LPN #3, on 03/16/12 at 3:45 PM, revealed she made rounds with Resident #1's Physician, on 02/01/12 around 4:00 PM, and the resident told the doctor he/she had pain so the Physician ordered Tylenol. Further interview revealed she did not inform the Physician of the resident's earlier report of blood in the stool because she thought the DON had already notified the Physician. Review of NNs, dated 02/01/12 at 10:00 PM, revealed Resident #1's color was pale. Further review of NNs revealed the resident had complained of blood in the stool earlier, but none had been noted thus far. Interview with LPN #5, on 03/16/12 at 7:00 PM, revealed she worked the evening of 02/01/12 and noticed Resident #1 was "pretty pale" that night. Further interview revealed she did not notify the Physician about Resident #1's complaints of having blood in the stool because she thought since it was noted in shift change report that the Physician had been earlier that evening that he was already aware of Resident #1 reporting blood in the stool. Review of NNs, dated 02/02/12 at 8:10 AM, revealed Resident #1 was weak, jaundiced, unresponsive at times and appeared to have blood in the urine and stool. Further review of the NNs revealed the Physician was notified and the resident was sent to the hospital for evaluation. Review of the hospital discharge summary,	F 282		

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F 282	Continued From page 52 history and physical, and emergency room records, from 02/02/12 through 02/07/12 revealed Resident #1 had an INR of 8, a Hemoglobin of 5.8 grams per deciliter (normal range was 12.0-16.0 g/dL) and Hematocrit of 19.2 percent (normal range was 36.0-48.0 %). Further record review revealed Resident #1 was given 10 mg of Vitamin K by slow IV infusion in the emergency room, four (4) units of Red Blood Cells (RBC) upon admission to the hospital and diagnosed with Anemia from Acute Upper Gastrointestinal Bleed from Coumadin Toxicity. Interview with Resident #1's Physician, on 03/16/12 at 3:15 PM and on 03/20/12 at 2:30 PM, revealed Resident #1 was alert and oriented and he would have expected when Resident #1 informed the staff there was blood in the resident's stool that he would have been notified. 2. Record review revealed the facility admitted Resident #4 on 12/23/11 with diagnoses which included Dementia, Diastolic Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Hypertension. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/30/11, revealed the facility assessed the resident as having short term and long term memory loss and as having moderate impairment in cognitive skills. Review of the Comprehensive Plan of Care for Resident #4, dated 01/03/12, revealed the resident had CHF related to weakness and fatigue secondary to Diastolic Heart Failure, Mild Pulmonary Hypertension, and Diastolic Dysfunction. The goal stated the resident would	F 282		

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F 282	Continued From page 53 have clear lung sounds, and heart rate and rhythm within normal limits. The interventions included; checking breath sounds and monitoring for labored breathing, observing for any signs and symptoms of CHF which included dependent edema of the legs and feet, periorbital edema, shortness of breath on exertion, dry cough, distended neck veins, weakness, increased heart rate, lethargy and monitoring weight gain unrelated to intake. Interview, on 03/19/12 at 2:15 PM, with the DON and further review of the Weights and Vital Sign Summary revealed the resident's weight increased from 140.2 pounds on 03/05/12 to 150.4 pounds on 03/10/12, a 10.2 pound weight gain in five (5) days and then an additional 5.8 pound weight gain was noted on 03/19/12 when the resident's weight was recorded as 156.2 pounds, a total of 11.4% weight gain from 03/05/12 to 03/19/12; however, there was no documented evidence the facility was monitoring the weight gain per the Plan of Care and no documented evidence the Registered Dietician (RD) or Physician were notified of the significant weight gains. Interview with LPN #1, on 03/19/12 at 4:00 PM, revealed she was the nurse responsible for reviewing weights and monitoring weight gain or loss of five percent (5%) or more. She stated if a weight gain was noted she was to observe the resident for difficulty breathing and if the resident was having difficulty she would auscultate the lungs and check for edema in the lower extremities. She stated she did not always communicate gains or losses to the nurses and she was unsure of who was responsible for	F 282		

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F 282	Continued From page 54 notifying the Physician of weight gains and losses. Further interview, on 03/19/12 at 2:15 PM, with the DON revealed according to the Weights and Vital Sign Summary, the Registered Dietitian (RD) should have been notified of the weight gain as part of the Comprehensive Care Plan intervention of monitor for weight gain unrelated to increased intake. However, interview, on 03/19/12 at 4:30 PM, with the Registered Dietician (RD) revealed she was unaware Resident #4 had a weight gain. The RD stated she should be notified of significant weight gains or losses. Interview, on 03/19/12 at 3:30 PM, with the DON, revealed the facility's process for monitoring weights was the Restorative Aide (RA) was to obtain weights and distribute copies of the weights to the nurse on duty and was also to leave a copy of the weights in the DON's office. She stated LPN #1 was responsible for completing the weekly Nutritional at Risk (NAR) Notes for residents on weekly weights. She further stated if significant weight gains were noted, LPN #1 should write a "nutritional note" which would include how much food/fluid the resident was consuming and any supplements the resident was receiving which may contribute to the weight gain. Review of the Nutrition at Risk Progress Notes (NAR) documented by LPN #1, dated 03/10/12, revealed the resident had a weight gain of ten (10) pounds, edema, and would continue with current Plan of Care. She stated Resident #4 was not having shortness of breath on 03/10/12	F 282		

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F 282	Continued From page 55 and she did not feel the need to assess the resident. Interview with the DON, on 03/19/12 at 2:15 PM, revealed LPN #1 should have assessed Resident #4 as needed if weight gains were significant to included assessing the resident's lungs as well as checking for pitting edema of the lower extremities. Further interview revealed LPN #1 should have notified the Physician of the 10.2 pound weight gain on 03/10/12. Continued interview revealed the (NAR) Note was not comprehensive to include those factors. She stated part of monitoring for weight gain was assessing, documenting and intervening on noted weight fluctuations. Continued interview with the DON revealed she recorded the weights into the computer each week after they were obtained and when she entered the 03/10/12 weight for Resident #4 into the computer on 03/12/12, she noted the weight gain and brought it to staff's attention in order for the Physician to be notified. However, interview, on 03/22/12 at 9:00 AM with LPN #4, revealed she was unaware of any weight changes and had not notified the Physician of a weight gain. Review of the Weights and Vitals Signs Summary Report revealed even though the facility noted a 10.2 pound weight gain on 03/10/12 there was no further weights obtained and no documented evidence Resident #4's weight was monitored until a weight was obtained on 03/19/12, nine (9) days later which was 150.4 pounds, an additional 6.2 weight gain, for a total weight gain of 11.4%.	F 282		

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F 282	Continued From page 56 Review of the Physician/NP/PA Communication and Progress Note, dated 03/19/12 at 11:00 AM, revealed the resident's respirations were slightly labored and the resident's oxygen saturation was eighty-eight percent (88%). Review of the Nurses Notes, dated 03/19/12 at 3:00 PM, revealed Resident #4 was being sent to the hospital emergency room for evaluation, the resident's oxygen saturation was eighty-eight percent (88%) to eighty-nine percent (89%) with oxygen at two (2) liters per nasal cannula, the resident had bilateral lower extremity edema and respirations were slightly labored. Further interview with the DON, on 03/22/12 at 2:30 PM, revealed staff failed to follow the Plan of Care related to evaluating the weights once obtained. She stated staff failed to report the weight gains to the Physician which would be the responsibility of any nurse assigned. 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. Further interview revealed residents with significant weight gains and losses were to be taken to the Quality of Care (QOC) Meeting weekly and discussed by the interdisciplinary team; however, Resident #4 was not discussed in the meeting the week of 03/11/12. She stated there was no QOC Meeting held that week due to the start of the standard survey on 03/13/12. Interview, on 03/20/12 at 1:45 PM, with the Attending Physician/Medical Director, revealed he was unaware of the resident having weight gains	F 282		

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F 282	Continued From page 57 in March 2012 and if he had known of the weight gain he would have checked a BNP lab test to further test for CHF. Continued interview with Resident #4's Physician, on 03/27/12 at 5:00 PM, revealed he would have started the Lasix (diuretic medication) at the facility had he known of the weight gain and would have attempted other avenues of care and interventions and stated the weight gain played a vital role in the resident's CHF status. Review of the AOC revealed the following: 1. The facility reviewed all clinical records of all resident's receiving anticoagulant therapy which was completed by the Licensed Nursing Home Administrator (LNHA) and the DON on 03/17/12, to ensure there were no negative outcomes as a result of their anticoagulant therapy and ensure the Care Plan was being followed. 2. On 03/28/12, to ensure appropriate care was being provided, the Executive Director (ED), the Vice President of Medical Services, and the (LNHA), reviewed the medical records of all residents who had a diagnosis of CHF and other residents with other chronic conditions which would require ongoing monitoring. 3. 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 and proper physical assessment as well as documentation requirements and following the Care Plan. On 03/28/12, an in-service was conducted by the LNHA at 5:00 PM to review	F 282		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 58 symptoms of CHF and proper assessment and documentation for resident's with CHF, 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. On 03/28/12, an in-service was conducted with all licensed nursing staff with the exception of two LPNs which would be in-serviced before returning to work. 4. As part of the facility's ongoing QA program, the LNHA or the DON, will audit one hundred (100) percent of resident charts that are currently receiving Coumadin therapy daily for the next thirty (30) days, and then weekly thereafter, to provide a double check to ensure proper assessment of resident concerns, documentation which details care provided to each resident and that meets current professional standards according to each resident's plan of care. Also 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 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. The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows: *Interview with the DON, on 03/27/12 at 3:00 PM, revealed on 03/17/12 the medical chart for all residents receiving anticoagulant therapy was reviewed.	F 282		

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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 282	Continued From page 59 *Interview with the LNHA, on 03/29/12 at 10:00 AM, revealed on 03/28/12 all medical records were reviewed, of residents with a diagnosis of CHF and residents with other chronic conditions which would requires ongoing monitoring. *Interview with the DON, on 03/27/12 at 3:00 PM, revealed all licensed staff was in-serviced on reviewing physician notification, as well as documentation requirements and following the Plans of Care. Review of the in-service sign in sheet, titled Documentation with Physician Notification , revealed all licensed staff attended the in-service. Interview with LPN #2, on 03/27/12 at 10:00 AM, interview with LPN #4, on 03/27/12 at 11:15 AM, interview with LPN #1, on 03/27/12 at 2:00 PM, interview with LPN #6, on 03/27/12 at 3:30 PM, interview with LPN #3, on 03/27/12 at 3:45 PM, revealed they had attended the in-service conducted on 03/17/12 at 1:00 PM and were knowledgeable of the information covered in the in-service. *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 of the in-service, physician notification, signs and symptoms of CHF, and documentation. Review of the sign in sheet for the inservice revealed all staff, with the exception of LPN #7 was in attendance. Interview with LPN #2, on 03/29/12 at 9:00 AM, interview with LPN #4, on 03/29/12 at 9:15 AM, interview with LPN #1, on 03/29/12 at 9:20 AM, interview with MDS Nurse #3, on 03/29/12 at 9:30 AM, interview with LPN #6, on 03/29/12 at 9:30 AM, interview with LPN #3, on	F 282		

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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 282	Continued From page 60 03/29/12 at 9:40 AM, interview with LPN #5, on 03/29/12 at 9:45 AM, interview with LPN #9, on 03/29/12 at 9:50 AM, interview with LPN #8, on 03/29/12 at 10:00 AM, revealed they had attended the inservice conducted on 03/28/12 at 5:00 PM and were knowledgeable of the information covered in the inservice. Interview with LPN #7, on 03/29/12 at 10:05 AM, revealed the LNHA had contacted her and informed her that before she was able to return to work she would have to attend an inservice. *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, and documentation and to ensure the care plans were being implemented. She further stated she would be doing the audits daily for thirty (30) days and then weekly thereafter. *Review of the audit titled, "Review of Residents with CHF" on 03/29/12, revealed daily audit of the resident charts for residents 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 to ensure care plans were being followed. She further stated these audits would be reviewed daily (Monday through Friday) in the morning meetings and then every month in the QA committee meetings.	F 282		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F309 It is and was on the days of survey the policy of Hilltop Lodge to ensure each resident receives and facility	

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

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F 309	Continued From page 61 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to have an effective system in place to ensure care and services were provided to attain and maintain residents' highest practicable physical well-being for one (1) of twenty-four (24) sampled residents (Resident #1). Resident #1's Physician ordered an increase of Coumadin from 3.0 milligrams (mg) to 5.0 mg every day, on 01/06/12, and an order to have a PT/INR [Prothrombin (PT) and International Normalized Ratio (INR)] be completed on 01/11/12. On 01/08/12, Resident #1's Physician ordered the resident to be given 50 mg Levaquin (an antibiotic) 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. The results of the PT/INR obtained on 01/11/12 were a PT of 30.3 seconds and an INR of 2.9 (normal range of PT 9.5-11.8 seconds and therapeutic range of INR 2.0-3.0). The results were faxed to the	F 309	provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 1. Resident #1 remains in the facility and her current PT/INR is within therapeutic range. Resident #1's care has been reviewed with her attending physician and revision made to her labs and plan of care. 2. All residents on Coumadin therapy and CHF are being monitored daily to ensure appropriate care is being provided. The Director of Nursing is monitoring Monday through Friday and the charge nurse on Saturday and Sunday. 3. An inservice was conducted on 3/28/12 at 5:00 p.m. to review signs and symptoms of CHF, physician notification, as well as lab monitoring. This inservice was conducted by Stacey Richardson RN, BSN, LNHA. All licensed staff were in attendance with the exception of two LPN's which work other jobs.	

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	185307		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

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F 309	Continued From page 62 Physician on 01/11/12. The Physician faxed back to the facility, on 01/13/12, to obtain a PT/INR in one month. 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 noted to be weak and unresponsive at times and had blood in his/her urine and stool. Resident #1 was sent to the hospital via ambulance, was given 10 mg of vitamin K by slow IV infusion in the emergency room, given four (4) units of Red Blood Cells (RBC) upon admission to the hospital and diagnosed with Anemia from Acute Upper Gastrointestinal Bleed from Coumadin Toxicity. The facility's failure to ensure adequate monitoring of Coumadin dosages and PT/INR levels, caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy identified on 03/16/12 and was determined to exist on 01/08/12. The facility was notified of the Immediate Jeopardy on 03/16/12. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/23/12 with the facility alleging removal of the Immediate Jeopardy on 03/18/12. Immediate Jeopardy was verified to be removed on 03/18/12 as alleged prior to exiting with the facility on 03/29/12, with remaining non-compliance at 42 CFR 483.25 Quality of Care, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure appropriate care and services are provided to	F 309	These two LPN's were inserviced prior to returning to work on 3/31/12 and 4/2/12. 4. As part of the facility's ongoing Quality Assurance Program the Administrator or Director of Nursing (Monday through Friday) and the charge nurse (Saturday and Sunday) will daily review all charts of those individuals who have a diagnosis of CHF and receive Coumadin therapy to ensure proper care and services are being provided. These audits will be performed for the next ninety (90) days and then weekly thereafter. In addition, daily the Director of Nursing, MDS Assessment Nurse, and therapy staff will review resident care to ensure necessary care and services are being provided to each resident. This review will be achieved by reviewing daily report, incidents, therapy needs, as well as physician orders. This process will be ongoing. 5. 4/3/12	4/3/12

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F 309	Continued From page 63 residents. The findings include: 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." 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. 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 the medical record revealed Resident #1 was admitted to the facility on 08/05/10 with diagnoses which included Atrial Fibulation, Deep Vein Thrombosis, Chronic Renal Failure, and Colectomy for Cancer. Review of Physician's faxed orders, dated 01/06/12, revealed the	F 309		

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F 309	Continued From page 64 Physician ordered Resident #1's Coumadin increased from 3 mg to 5 mg everyday and a PT/INR obtained on 01/11/12. Review of a Physician's Telephone Order, received at 5:20 PM on 01/08/12, revealed the physician ordered Levaquin at 750 mg everyday for 5 days for Upper Respiratory Infection. Review of a fax from the pharmacy, received at the facility at 8:01 PM on 01/08/12, revealed the pharmacy alerted the facility of a potential drug interaction between Coumadin and Levaquin and the need to monitor INR and watch for signs of bleeding. Review of a Quarterly Minimum Data Set, dated 01/09/12, revealed the facility assessed Resident #1 as being alert and oriented with a BIMS score of 15 out of 15, indicating the resident was cognitively intact. The facility assessed the resident as needing limited assistance with one person physical assist to use the toilet. Review of the Comprehensive Plan of Care, dated 01/10/12, revealed a plan of care was developed related to the resident receiving Coumadin therapy with interventions to report increased weakness, bleeding gums, blood in stool or urine. A review of the laboratory report, dated 01/11/12, revealed Resident #1's PT was 30.3 seconds (normal: 9.5-11.8) and the INR was 2.9 (standard anticoagulant range: 2.0-3.0). The results were faxed to the Physician on 01/11/12. The Physician documented on the lab report 'NNO' (no new orders) and to repeat the PT/INR in one month. Review of Resident # 1's Anticoagulant (Coumadin) Log revealed the results of the PT/INR obtained on 01/11/12, and the next scheduled PT/INR was not documented on the	F 309		

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F 309	Continued From page 65 log. Review of Physician's Orders, dated 01/27/12, revealed the Physician ordered Macrobid twice a day for 7 days for Resident #1 related to the resident having a UTI (Urinary Tract Infection). Review of the Medication Administration Record (MAR) revealed Resident #1 received the Macrobid from 01/27/12 through 02/01/12. Interview with Consultant Pharmacist #1 and Consultant Pharmacist #2, on 03/20/12 at 10:00 AM, revealed all antibiotics could raise the INR of a resident on Coumadin therapy. Further interview revealed antibiotics, such as Levaquin Bactrim and Cipro, could raise the INR the most and it was recommended to have an INR obtained ten days after being off the antibiotic. Review of Nurses Notes (NN), dated 02/01/12 at 12:00 PM, revealed Resident #1 stated to the Director of Nursing (DON) that he/she had passed some blood in his/her stool and the resident had flushed the commode before any staff could evaluate or see the stool. The DON documented she asked the resident if he/she wanted to go to the emergency room since the resident was on Coumadin, but the resident refused. The DON further documented she had explained to Resident #1 the Physician would be in that day and had stressed to the resident not to flush the commode until the nurse viewed any bowel movements. Interview with the DON and Licensed Practical Nurse (LPN) #1, on 03/16/12 at 4:00 PM, revealed they both were in the room when Resident #1 stated the he/she had passed some	F 309		

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F 309	Continued From page 66 blood in the stool. Further interview revealed they did not assess Resident #1 because the resident had flushed the commode before they could see any blood. The DON and LPN #1 indicated they did not assess Resident #1, such as obtaining vitals, nor did they call the resident's Physician because they knew the Physician would be in later that day to make rounds. Interview with LPN #3, on 03/16/12 at 3:45 PM, revealed she made rounds with Resident #1's Physician around 4:00 PM and the resident told the doctor he/she had pain so the Physician ordered Tylenol. Further interview revealed she did not inform the Physician of the resident's earlier report of blood in the stool because she thought the DON had already notified the Physician. Review of NNs, dated 02/01/12 at 10:00 PM, revealed Resident #1's color was pale. Further review of NNs revealed the resident had complained of blood in the stool earlier, but none had been noted thus far. Interview with LPN #5, on 03/16/12 at 7:00 PM, revealed she had worked the evening the of 02/01/12 and noticed Resident #1 was "pretty pale" that night. Further interview revealed she thought the Physician was already aware of Resident #1 reporting blood in the stool. Review of NNs, dated 02/02/12 at 8:10 AM, revealed Resident #1 was weak, jaundiced, unresponsive at times and appeared to have blood in the urine and stool. Further review of the NNs revealed the Physician was notified and ordered the resident to be sent to the hospital for	F 309		

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F 309	Continued From page 67 evaluation. Review of the hospital discharge summary, history and physical, and emergency room records, from 02/02/12 through 02/07/12 revealed Resident #1 had an INR of 8, a Hemoglobin of 5.8 grams per deciliter (normal range was 12.0-16.0 g/dL) and Hematocrit of 19.2 percent (normal range was 36.0-48.0 %). Further record review revealed Resident #1 required 10 mg of Vitamin K by slow intravenous infusion in the emergency room and and four (4) units of Red Blood Cells (RBC) upon admission to the hospital. Resident #1 was diagnosed with Anemia from Acute Upper Gastrointestinal Bleed due to Coumadin Toxicity. 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 was not alerted by the facility of the potential drug interaction between Levaquin and Coumadin on 01/08/12. Further interview revealed Resident #1 was alert and oriented and he would have expected when Resident #1 informed staff there was blood in the resident's stool, at 12:00 PM on 02/01/12, that he would have been notified immediately as well as the nurse should have obtained vitals He indicated if he had been made aware of Resident #1 having blood in the stool, he would have also ordered a PT/INR be obtained. Interview with Resident #1's hospital Physician, on 03/28/12 at 2:00 PM, revealed since Resident #1 had an increase in the dosage of Coumadin it was a good practice to have a PT/INR obtained weekly for four (4) weeks and if stable it can be done monthly. Further interview revealed since	F 309		

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F 309	Continued From page 68 Resident #1 had been on Levaquin at the same time as the increased dosage of Coumadin that the nursing home should have been more diligent with monitoring the INR so the INR wouldn't have risen to the level of 8. Further interview revealed Coumadin was stopped upon admission to the hospital and there was no concern related to a Gastrointestinal (GI) bleed while at the hospital and the Coumadin Toxicity alone caused the GI bleed which occurred at the nursing home. A review of the AOC revealed the following: 1. The clinical records of all residents receiving anticoagulant therapy were reviewed by the LNHA and the DON on 03/17/12, to ensure there was ongoing monitoring and no negative outcomes as a result of their anticoagulant therapy. 2. 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. 3. As part of the facility's ongoing QA program, the LNHA or the DON, will audit one hundred (100) percent of resident charts that are currently receiving Coumadin therapy daily for the next thirty (30) days, and then weekly thereafter, to provide a double check to ensure proper assessment of resident concerns, documentation which details care provided to each resident and that meets current professional standards, and physician notification. Any issues that are identified will be reviewed by the LNHA and the	F 309		

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	185307		03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 69 Medical Director, and in turn will develop an action plan for any identified issue noted above. The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows: *Interview with the DON, on 03/27/12 at 3:00 PM, revealed on 03/17/12 the medical charts for all residents receiving anticoagulant therapy were reviewed to ensure there were no negative outcomes as a result of their anticoagulant therapy and after reviewing all the residents' medical records, it was determined there were no negative outcomes. *Record review of the facility's audits confirmed that all records of residents on Coumadin, and residents with chronic conditions which would require ongoing monitoring were reviewed. *Interview with the DON, on 03/27/12 at 3:00 PM, revealed all licensed staff was in-serviced on reviewing 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. Interview with LPN #2, on 03/27/12 at 10:00 AM, interview with LPN #4, on 03/27/12 at 11:15 AM, interview with LPN #1, on 03/27/12 at 2:00 PM, interview with LPN #6, on 03/27/12 at 3:30 PM, interview with LPN #3, on 03/27/12 at 3:45 PM, revealed they had attended the in-service conducted on 03/17/12 at 1:00 PM and were knowledgeable of the information covered in the	F 309		

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F 309	Continued From page 70 in-service. *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 were reviewed on a daily basis and the review 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 would review on Saturday and Sunday, for the next ninety (90) days and then weekly thereafter. She further stated these audits would be reviewed daily (Monday through Friday) in the morning meetings and then every month in the QA committee meetings. Continued interview revealed Administration had participated in the creation of the audit forms and the in-services, and assured staff was knowledgeable on all information covered in the in-service.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314	F314 It is and was on the day of survey the policy of Hilltop Lodge for all residents to receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	

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F 314	Continued From page 71 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that a resident having pressure received necessary treatment and services to promote healing for one (1) of twenty-four (24) sampled residents (Resident #2). Resident #2 had a change in wound characteristic on 02/07/12 from a red area to deep purple with enlargement in size which was identified as deep tissue injury. There was no documented evidence the Physician was notified in order to receive treatment interventions. The findings include: 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, Alzheimer's Disease, Dementia, Depression, and Flaccid Hemiplegia Affecting Unspecified Side. Review of the resident's Minimum Data Set (MDS) Assessment, dated 08/29/11, revealed the resident was at risk for pressure sores and had one Stage I pressure ulcer identified. The Braden Scale assessment, for predicting pressure sore risk assessed the resident as high risk. Further review of the resident's Quarterly MDS Assessment, dated 02/27/12, revealed the	F 314	1. Resident #2 remains in the facility and the area to her right lateral foot healed on 3/27/12. This area was first noted on 2/21/12 as a 0.6 by 1.8 centimeter purple area over the bony prominence and treatment orders were obtained by a licensed nurse. 2. All residents are assessed weekly by licensed staff for skin breakdown. Daily the nursing staff monitors skin condition during routine care. All residents with skin breakdown are monitored weekly in the facility's Quality of Care meeting. Those in attendance include the Executive Director, Administrator, Director of Nursing, MDS/Care Plan Nurse, Social Service Director, Activities Director, and Dietary Manager. No other residents were identified by the alleged deficient practice. 3. An in-service was conducted by the Executive Director for all licensed staff reviewing physician notification on 3/17/12. All licensed staff were present for the inservice. 4. As part of the facility's ongoing Quality Assurance program the Director of Nursing will monitor residents with stageable skin	

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F 314	Continued From page 72 resident had one (1) Unstageable (deep tissue) wound identified. The Braden Scale assessment, for predicting pressure sore risk assessed the resident as high risk. Review of Resident #2's Care Plan, dated 09/01/11, revealed skin integrity was identified as a problem and the goal was to maintain skin at optimal integrity, and ulcer will heal. Interventions included to turn and reposition every two hours. Encourage a pillow between legs. Use turn sheet to reposition, air mattress, heel protectors to feet while in bed, apply DuoDerm to outer right foot red area, change every seven days. Record review for Resident #2 revealed Wound Care Summary documentation noted on 07/16/11 the resident developed a one (1) centimeter (cm) red area located on his/her outer right foot along the bony prominence near the base of the little toe. Resident #2 had an order to apply DuoDerm to the site every seven days. Review of subsequent Wound Care Summary weekly progress notes revealed they continued to describe the wound area as one (1) cm area of redness. Continued review of the record revealed, the 02/07/12 progress note described a change in the characteristic of the wound site. The document described the site was now 0.6 cm by 1.8 cm, and was deep purple skin with smooth texture. There was no documentation in the record the Physician had been notified of the change. The 03/07/12 weekly progress note described the site as being a deep purple black area. A Physician's order, for 03/07/12, changed wound care to wrap the Deep Tissue Injury (DTI) with Kling and	F 314	condition as well as deep tissue injuries to ensure the Medical Director is aware of the condition and treatment as well as weekly progress; this process will be ongoing. 5. 3/30/12	3/30/12

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F 314	Continued From page 73 change daily. The weekly nurse note on 03/11/12 identified the wound as a DTI. Observation of the site, on 03/16/12 at 10:00 AM, revealed a hard, brown scab which measured 0.8 by 1.2 cm. The resident was in bed and had heel protectors in place prior to the skin assessment. Interview with Restorative Assistant RA#1, on 03/16/12 at 10:25 AM, revealed they worked with the resident because of contractures, the resident's legs draw back so they used braces on his/her lower extremities about four (4) hours a day or as much as tolerated. The resident was turned and repositioned about every two (2) hours. In addition, staff also put heel protectors on when the resident was in bed. Interview about Resident #2's wound with Licensed Practical Nurse (LPN) #4, on 03/16/12 at 2:40 PM, revealed the site began on 07/16/11 as a red area. The Physician ordered DuoDerm to be applied every seven (7) days. The resident had circulation problems and the goal was to protect the area and prevent further breakdown. On 02/07/12 the site changed, it was measured as 0.6 by 1.8 cm and it appeared to be more like a DTI. Further interview revealed she could not verify the Physician was notified about the change in the wound on 02/07/12. She stated she obtained an order to change the wound care on 03/07/12, when the area around the wound began to form a dark crust. Interview with Resident #2's Physician/Medical Director, on 03/20/12 at 1:45 PM, revealed he could not say he was made aware of the change in Resident #2's wound on 02/07/12. He stated	F 314		

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F 314	Continued From page 74 he may have changed the treatment by providing nutritional supplements, such as Zinc and Vitamin C, if given the whole history at that time. It would be more about adding nutrients, than changing the dressing that was being applied. Interview with the Director of Nursing (DON) about Resident #2's wound, on 03/23/12 at 1:00 PM, revealed LPN #4 told the DON she had "messed up" and could not remember talking to the Physician about the wound change on 02/07/12. Further interview with the DON revealed the Physician should have been informed of the wound change in case he wanted to change the treatment.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system in place to provide adequate supervision when the risk of resident to resident altercation was identified for three (3) of twenty-four (24) sampled residents, (Resident #5, #11 and #19) and one (1) unsampled resident, Unsampled	F 323	F323 It is and was on the days of survey the policies of Hilltop Lodge to ensure that the resident environment remains as free of accident hazards as possible. 1. Resident # 19 has a BIM score is 5. This resident has not caused injury to any resident or staff. The resident with a history of dementia had an incident on 3/24/12 involving yelling with another resident. The residents made no contact with one another and were immediately separated by the nurse. On 3/27/12, the resident was sent out for psychiatric evaluation at	

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F 323	Continued From page 75 Resident #D. Resident #19 had a history of abusing other residents. The facility failed to ensure adequate supervision to ensure each resident was protected from abuse as evidenced by the failure to implement a plan of care a resident with a personal history of being at risk of abusing other residents. The facility also failed to develop interventional strategies in preventing occurrences and monitoring changes in Resident #19's aggressive behavior and failed to reassess current interventions for appropriateness on a regular basis. Resident #19 exhibited three (3) different episodes of aggressive behaviors with two (2) of the incidences resulting in Resident #19 slapping one (1) unsampled and one (1) sampled resident (Resident #11) in the face. The facility failed to notify Resident #19's state appointed guardian of two (2) of the three (3) episodes. The facility failed to provide supervision to protect residents after the facility was aware of Resident #19 displaying aggressive behaviors towards other residents. 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. While the facility separated the residents and changed Resident #19's room assignment, there was no documented evidence the facility implemented measures to prevent the recurrence of Resident #19's aggressive behaviors towards other residents. On 03/04/11, it was observed by facility staff, that Unsampled Resident #D attempted to touch Resident #19 on the hand during meal service, when Resident #19 reached and slapped	F 323	approximately 8:30p.m. The psychiatric unit refused to admit the resident and the resident was sent back to the facility at approximately 3:30a.m. on 3/28/12. One-on-one supervision was initiated upon the resident's return to the facility. At 8:00a.m., the resident's guardian was notified to inquire about placement at another facility. The guardian agreed to placement and resident was transferred at 9:00a.m. on 3/28/12. Resident #5 was immediately separated from resident #19 after the incident on 12/31/11. On 4/9/12 resident #5 was discharged from the facility to be located closer to his family. Resident #11 remains in the facility. There was no contact with the other resident and this was a verbal altercation with resident #19. These two residents were immediately separated and 15 minute checks were initiated for resident #19. 2. All residents with behaviors have been reviewed by the Social Service Director and Administrator (3/28/12). Behavior monitoring logs are in place for each individual and are being completed as directed by licensed staff only.	

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F 323	Continued From page 76 Unsampled Resident D across the face. There was no documented evidence the facility implemented measures to prevent the recurrence of the continued aggressive behaviors of Resident #19. On 03/24/11, Resident #11 was waiting to enter the restroom when Resident #19 walked around Resident #11 and entered the restroom first. Resident #11 yelled at Resident #19 and Resident #19 yelled back and drew back his/her fist in an attempt to hit Resident #11. In addition, the facility failed to ensure the residents' environment remained free from accident hazards as evidenced by observation on the initial tour, on 03/13/12, revealed chemicals and toiletries found in an unlocked cabinet in the shower room and toiletries left on the back of toilets in common resident bathrooms which were accessible to the facility's residents. The facility's failure to provide adequate supervision to protect residents from abuse placed residents at risk for serious injury, harm, impairment or death. The facility was notified of the Immediate Jeopardy on 03/28/12. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/28/12 with the facility alleging removal of the Immediate Jeopardy on 03/29/12. Immediate Jeopardy was verified to be removed on 03/29/12 prior to exiting with the facility on 03/29/12 with remaining non-compliance at 42 CFR 483.13 Resident Behavior and Facility Practice, with a scope and severity of a "D", while the facility develops and implements a Plan of Correction and the facility's Quality and Assurance continues to monitor and ensure residents receive adequate supervision to	F 323	3. An inservice was conducted on 3/28/12 with all licensed nursing staff with the exception of two LPNs which work other jobs. These two LPNs will be inserviced prior to returning to work on 3/31/12 and 4/2/12. This inservice relates to the behavior monitoring program and tracking of behaviors, as well as physician and family notifications of such behaviors. If resident to resident altercations occur, licensed staff have been inserviced to initiate 15 minute checks for 72 hours, if additional behaviors are exhibited one-on-one supervision and immediate psychiatric evaluation will take place. The licensed staff were instructed to immediately notify the Executive Director or Administrator if resident to resident physical altercations take place to ensure resident safety. 4. As part of the facility's ongoing Quality Assurance program the Social Service Director 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	

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F 323	Continued From page 77 ensure a safe environment for the residents. The findings include: 1. 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. Interview with the Executive Director (ED), on 03/27/12 at 4:00 PM, revealed the Behavior Monitoring flow sheets were to be completed by licensed nursing personnel every shift. She further stated the facility did not have an assigned staff to monitor the flow sheets. Interview with the Director of Nursing (DON), on 03/27/12 at 2:55 PM, revealed if a resident	F 323	on Saturday and Sunday. The chart of any resident exhibiting behaviors will be reviewed by the Social Service Director to ensure proper follow-up. The Social Service Director will communicate with MDS Coordinator/Administrator to update care plan interventions if behavior is exhibited. Daily (Monday through Friday) the Director of Nursing, therapy staff, and Social Services will meet to review resident care needs, incidents, and plans of care. Daily the Director of Nursing (Monday through Friday) and the charge nurse (Saturday and Sunday) will monitor the physical environment to ensure proper storage of chemicals and any other potential accident hazards. This process will be ongoing. 5. 3/30/12	3/30/12

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F 323	Continued From page 78 exhibited a behavior the Physician could not address, the facility may send a resident to a behavioral unit. Interview with the Administrator, on 03/27/12 at 6:30 PM, revealed the facility previously used a webcam Psychiatric Service to assist with residents' behaviors but no longer utilized the services of a Psychiatric webcam. Further interview revealed the facility did not have a current service for evaluation of residents' behaviors and the residents would have to be sent out for these services. Interview with Social Services Director (SSD), on 03/27/12 at 6:25 PM, revealed when behavioral incident investigation was initiated, it was completed by the ED and the DON and upon completion of the investigation she was informed of the outcome. Further interview revealed, if she needed to make a referral at that time she would follow up with the referral. Continued interview revealed if no intent of harm was indicated from the investigation, she would not necessarily follow up with a referral. Review of the facility's policy titled, "Care Plan Committee/Team", dated 01/09/03, revealed the care planning committee/team was responsible for maintaining care plans on a current status through periodic review and updating. Further review of the policy titled, "Care Plan-Using the Plan", dated 01/09/03, revealed changes in the resident's condition must be reported to the Registered Nurse (RN) assessment coordinator so that a review of the resident's assessment and care plan could be made. Further review revealed daily care and documentation must be consistent	F 323		

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F 323	Continued From page 79 with the resident's care plan. Review of Resident #19's medical record revealed the facility admitted the resident on 08/02/10, with diagnoses which included Alcohol Dementia, Depression, Alzheimer's Disease and Schizophrenia. Continued review of the record revealed Resident #19 had been declared mentally incompetent and a State Guardian had been appointed. Interview with the DON, on 03/27/12 at 7:05 PM, revealed Resident #19 had been a resident at a Personal Care Home and a Skilled Nursing Facility owned by the corporation, therefore the facility was aware of Resident #19's past history of aggressive behaviors. Interview with the State Guardian, on 03/28/12 at 9:30 AM, revealed Resident #19 has had a history of hitting/slapping people. He stated when Resident #19 was a resident at the Personal Care Home he/she slapped other residents and when he/she was a resident at the Skilled Nursing Facility he/she threatened to hit a visitor and struck a resident causing an injury to the resident's eye. Review of Resident #19's Plan of Care, dated 07/25/11, revealed a problem that the resident had a potential for violence related to behavioral problems in the past, auditory hallucinations, delusions, repeating questions for pop and cigarettes secondary to Dementia, Alzheimer's and Schizophrenia. Review of the Physician's orders, dated 12/27/11 revealed Resident #19 was prescribe Risperdal 0.5 milligram (mg) twice daily (an antipsychotic medication) and Haldol 1 mg four (4) times a day as needed (an antipsychotic medication). Review of the facility's, "Resident	F 323		

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F 323	Continued From page 80 Incident/Accident Report", dated 12/31/11 at 8:00 PM, revealed Resident #19 had an altercation with his/her roommate (Resident #5), slapped his/her roommate in the face, resulting in the Resident #5 having facial redness. Further review revealed Resident #19 refused to go to the Emergency Room (ER) for an evaluation. There was no documentation the State Guardian was notified of Resident #19's aggressive behavior and no evidence the State Guardian was made aware of Resident #19's refusal to been sent out for an evaluation. Interview with the ED, on 03/27/12 at 4:00 PM, revealed Resident #19 the State Guardian should have been the one to make the decision of the ER visit after the 12/31/11 incident, not the resident. Further interview validated the facility had assessed the resident as not making sound decisions, but yet the facility allowed the resident to decline an ER visit for possible psychiatric treatment. Continued interview revealed, the facility should have contacted the State Guardian at the time of the incident. Interview with the Executive Director (ED), on 03/27/12 at 5:25 PM, revealed the facility completed an investigation for the 12/31/11 incident and determined due to Resident #19 being incompetent, the facility felt Resident #19 had no intent to harm anyone. Further interview revealed, Resident #19 was stable as he/she was moved to another room. Review of the Care Plan revealed no documented evidence of new interventions to address Resident #19's behavior following the 12/31/11 incident. Review of Resident #19's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 01/15/12, revealed the facility assessed the	F 323		

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	185307		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

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F 323	Continued From page 81 resident to have no behavior symptoms exhibited. Interview with the DON, on 03/27/12 at 2:55 PM, revealed she was unsure if the Plan of Care was updated at the time of the 12/31/11 incident or not. Further interview confirmed the 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. Review of the Behavior Monitoring flow sheet for 12/2011 revealed no documented evidence the facility identified, documented or addressed Resident #19's aggressive behavior episode on 12/31/11. Interview with Social Services Director (SSD), on 03/27/12 at 6:25 PM, revealed she was aware of the incident, on 12/31/11, when Resident #19 hit Resident #5 but did not make a referral even though Resident #19 refused immediate transfer for evaluation on 12/31/11. She further stated she did not contact the State Guardian regarding Resident #19's behaviors. Review of the facility's "Resident Incident/Accident Report", dated 03/04/12 at 5:15 PM, revealed Resident #19 had an altercation with Unsampled Resident D during meal service. Further review revealed Resident #19 slapped Unsampled Resident D across the face when he/she reached and grabbed Resident #19's hand. Interview with the ED, on 03/27/12 at 8:30 AM, regarding the 03/04/12 incident revealed she must have been aware of the incident because	F 323		

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

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F 323	Continued From page 82 she had signed the report. Further interview revealed, Resident #19 had no intent to harm anyone. Interview with SSD, on 03/27/12 at 6:25 PM, indicated she was not aware of any specific incident with Unsampled Resident D. Review of the Care Plan revealed on 03/04/12 an intervention was added to separate Resident #19 and Unsampled Resident D and place Resident #19 on every fifteen (15) minute monitoring. Interview with the DON, on 03/27/12 at 2:55 PM, revealed the intervention for the 03/04/12 episode was not a clear and concise intervention. Review of the Behavior Monitoring flow sheet for 03/2012 revealed no documented evidence the facility identified, documented or addressed Resident #19's aggressive behavior. Further review of the record revealed no documented evidence the State Guardian was notified of the aggressive behavior. Further record review revealed no documented evidence social services reviewed the behavior flow sheet for patterns and concerns in behaviors that had the potential to affect the residents' overall psychosocial status and care delivery as per the facility's policy. Review of the facility's "Resident Incident/Accident Report", dated 03/24/12 at 8:40 AM, revealed Resident #11 was waiting to enter the restroom when Resident #19 walked around Resident #11 and entered the restroom first. Further review revealed both residents were separated as both residents drew back their fists to hit each other. Interview with License Practical Nurse (LPN) #1, on 03/27/12 at 5:40 PM, revealed she remembered the incident on 03/24/12 when the	F 323		

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F 323	Continued From page 83 two (2) residents wanted to hit each other. Further interview revealed, Resident #11 was sitting in the hallway waiting to go to the restroom when Resident #19 walked around him/her and entered the restroom before him/her. Resident #11 yelled at Resident #19, upon exiting the restroom, and Resident #19 drew back his/her fist and both residents continued to yell at each other. Continued interview with LPN #1, revealed when she filled out the Behavior Monitoring flow sheet she initialed the box to indicate the behavior occurred during her shift; however, review of the Behavior Monitoring flow sheet revealed no yelling or aggressive behavior was indicated on 03/24/12. Further review of the Plan of Care, revealed there was no documented evidence of any new interventions to address Resident #19's behavior following the 03/24/12 incident. Review of the Behavior Monitoring flow sheet revealed no documented evidence the behavior was identified, documented or addressed. Further record review revealed no documented evidence social services reviewed the behavior flow sheet for patterns and concerns in behaviors that had the potential to affect the residents' overall psychosocial status and care delivery as per the facility's policy. Further review of the record revealed no documented evidence the State Guardian was made aware of the aggressive behavior noted on 03/24/12. Interview with Resident #19's Physician/Medical Director, on 03/27/12 at 5:00 PM, revealed Resident #19 posed a risk to the other residents of the facility and in his professional opinion Resident #19 would be better suited in a more	F 323		

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F 323	Continued From page 84 appropriate placement. Further interview revealed, the facility had not discussed with him, the possibilities of an inpatient admission or placement in another facility. Continued interview identified he had attempted to change Resident #19's medications but was unsuccessful in the attempt. Interview with the State Guardian, on 03/28/12 at 9:30 AM, interview revealed he felt Resident #19 needed some psychiatric help. Continued interview revealed the State Guardian received a call on 03/27/12 indicating the facility was sending Resident #19 to a local Hospital for an evaluation but the facility did not inform him why Resident #19 was going. Further interview revealed Resident #19 was sent back to the facility on 03/27/12 and was discharged to the Sister Skilled Nursing Facility on 03/28/12. 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.	F 323		

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F 323	Continued From page 85 2. Review of the facility policy titled Equipment and Supply Storage, dated 01/09/03, revealed hazardous/toxic materials must be properly stored and labeled in accordance with current regulations. Drugs and biologicals must be stored in locked compartments. Observation on 03/13/12 at 10:45 AM during initial tour revealed the shower room on the long hall had an unlocked cabinet on the wall which contained two (2) gallon jugs of Lemon Klean Germicidal Cleaner with a label that stated, danger, keep out of reach of children. Interview with the MDS Nurse who was touring with the surveyor at the time, revealed the cleaner was used to clean the whirlpool bath. Also noted in the unlocked cabinet was two (2) tubes of Baza Protect with a label which stated, for external use only. Interview with the DON while in the shower room revealed the cabinet should be locked at all times. Further observation on 03/13/12 at 11:00 AM revealed resident bathroom D21 revealed toiletries on the back of the toilet including a bottle of Scope Mouthwash with a label which stated, call poison control if swallowed. There was also a basket of toiletries on the back of the toilet which included Right Guard Deodorant with a label which stated, keep out of the reach of children. Resident bathroom D11 had a caddy containing toiletries on the back of the toilet including Silkience Skin Care with a label that stated, keep out of the reach of children and call poison control if ingested, a bottle of Be Fresh Mouthwash with a label which stated, keep out of the reach of children, and a bottle of baby powder with a label which stated, keep out of the reach of	F 323		

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F 323	Continued From page 86 children. Continued observation on 03/14/12 at 4:40 PM revealed a bottle of hand sanitizer on the diningroom counter and on the physical therapy cart in the small shower room. Interview on 03/14/12 at 5:00 PM with the Director of Nursing (DON) revealed the hand sanitizer should not be left out accessible to residents. Review of the Material Safety Data Sheet (MSDS) for the product revealed ingestion may cause stomach upset and nausea, call a poison control center if ingested, and eye contact may cause eye irritation Further interview on 03/23/12 at 4:30 PM with the DON; revealed toiletries should be contained in a caddy and placed in the resident's bedside table drawer or in the closet and should not be left on the back of toilets for anyone to use. She further stated the facility had some wandering residents who were ambulatory and toiletries, and chemicals should not be left in an open area accessible to residents. A review of the AOC revealed the following: 1. On 03/27/12, the resident was sent out for a psychiatric evaluation at approximately 8:30 PM, and was sent back to the facility on 03/28/12 at 3:30 AM , after the psychiatric unit refused to admit the resident. On 03/28/12, one (1) on one (1) supervision was initiated upon the resident's return to the facility, the resident's guardian was notified to inquire about placement at another facility and agreed, and the resident was transferred at 9:00 AM on 03/28/12.	F 323		

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F 323	Continued From page 87 2. All residents with behaviors were reviewed by the Social Service Director (SSD) and Licensed Nursing Home Administrator (LNHA) on 03/28/12, and behavior monitoring logs were put into place for each individual and were to be completed as directed by licensed staff only. 3. On 03/28/12, an in-service was conducted with all licensed nursing staff with the exception of two LPN's which would be in-serviced 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 was to initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors were exhibited one (1) on one (1) supervision and immediate psychiatric evaluation would 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. 4. As part of the QA program, the SSD should daily (Monday through Friday) review the behavior monitoring/tracking log to ensure that they were being completed properly, the administrative staff member who was 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 behaviors were exhibited.	F 323		

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F 323	Continued From page 88 The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows: *Interview with the resident's guardian, on 03/28/12 at 12:00 PM, revealed the facility had contacted him related to placement for the resident. Review of the resident's medical chart revealed the facility had sent the resident out for a psychological evaluation on 03/27/12 and transferred the resident on 03/28/12. *Interview with the SSD, on 03/29/12 at 10:30 AM, revealed she had reviewed all the residents' medical records who had behaviors to ensure a Behavior Monitoring Log was in place for each individual resident and was completed as directed by the licensed staff. *Interview with the LNHA, on 03/29/12 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. *Review of the in-service revealed, staff was instructed on how to fill out the behavior monitoring program and tracking of behaviors form, as well as Physician and family notifications of such behaviors, if a resident to resident altercation occurred, licensed staff was in-serviced to initiate fifteen (15) minute checks for seventy-two (72) hours, if additional behaviors were exhibited one (1) on one (1) supervision and immediate psychiatric evaluation would take place, and to immediately notify the Executive Director (ED) or the LNHA if resident to resident	F 323		

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F 323	Continued From page 89 physical altercations took place to ensure resident safety. *Review of the sign in sheet for the inservice revealed all staff; with the exception of LPN #7, was in attendance. Interview with LPN #2, on 03/29/12 at 9:00 AM, interview with LPN #4, on 03/29/12 at 9:15 AM, interview with LPN #1, on 03/29/12 at 9:20 AM, interview with MDS Nurse #3, on 03/29/12 at 9:30 AM, interview with LPN #6, on 03/29/12 at 9:30 AM, interview with LPN #3, on 03/29/12 at 9:40 AM, interview with LPN #5, on 03/29/12 at 9:45 AM, interview with LPN #9, on 03/29/12 at 9:50 AM, interview with LPN #8, on 03/29/12 at 10:00 AM, revealed they had attended the in-service conducted on 03/28/12 at 5:00 PM and were knowledgeable of the information covered in the in-service. Interview with LPN #7, on 03/29/12 at 10:05 AM, revealed the LNHA had contacted her and informed her that before she was able to return to work she would have to attend an in-service related to residents with behaviors *Review of the monitoring tool titled, "Behavior Monitoring/Tracking Log" on 03/29/12, revealed daily audits of the record for residents with behaviors was conducted on 03/28/12, and was ongoing. *Interview with the 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 was to review on Saturday and Sunday. She further stated these audits would be reviewed weekly in the morning meetings and then every month in the QA committee meetings.	F 323		

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F 323	Continued From page 90 *Interview with Administration revealed they had participated in the creation of the audit forms and the in-services, and assured staff was knowledgeable on all information covered in the in-service.	F 323		
F 325 SS=J	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policies, it was determined the facility failed to have an effective system to ensure two (2) of twenty-four (24) sampled residents (Resident #1 and #4) were provided services to maintain body weight. The facility failed to ensure services were provided for Resident #4 who had a known diagnosis of Congestive Heart Failure (CHF). The resident was assessed by the facility as having 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). Although the	F 325	F325 It is and was on the day of survey the policy of Hilltop Lodge for all residents to maintain an acceptable nutritional status, unless a resident's condition is unavoidable; and for residents to receive a therapeutic diet when there is a nutritional problem. 1. Resident #1 remains in the facility and her current weight is one hundred and seventeen pounds. She was reviewed by the Dietician on 3/22/12. Resident #1 had order changes noted on 3/23/12 to send four ounces of milk for cereal at breakfast, 240 cc of fluids at 10:00am, 2:00pm, and at night, no carrots, and a discontinuation order of Colested, Calcium, and Simethicone. Orders for resident #1 also included to begin Lomotil 2.5mg by mouth every day for diaherra and Fibercon 625mg twice per day with full eight ounces of water. Resident #4 returned to the	

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F 325	Continued From page 91 Physician was notified on 03/12/12 of the resident having lung congestion and persistent edema in the lower extremities, there was no documented evidence the Physician or the Registered Dietician (RD) was notified of the weight gain and no documented evidence the facility followed their policy entitled "Changes in a Resident's Condition or Status". In addition, there was no documented evidence the facility followed the resident's Comprehensive Plan of Care related to CHF which stated the facility was to observe and monitor for weight gain. The resident was hospitalized on 03/19/12 with diagnoses of Exacerbation of Congestive Heart Failure with Pulmonary Edema and Hypoxia and expired at the facility on 03/24/12. (Refer to F157 and F282) In addition, Resident #1 was identified to have a potential for weight loss and poor nutritional status with a plan of care developed by the facility, however when the resident sustained a 5.8 pound/4.6 percent weight loss during hospitalization (02/02/12 through 02/07/12) there was no evidence the facility assessed the resident's nutritional status or altered treatment to prevent further weight loss. Resident #1 sustained an additional 3 pound/2.5 percent weight loss from 02/08/12 through 02/18/12, for a total of 8.8 pounds/7 percent weight loss in less than one month. The facility's failure to have an effective system to maintain acceptable parameters of nutritional status, such as body weight, for residents who have signs and symptoms of CHF, was likely to cause or has caused risk for serious injury, harm, impairment or death. Immediate Jeopardy was	F 325	facility following the hospitalization of 3/19/12. Following subsequent hospitalizations the resident has since died. 2. All residents' weights are reviewed weekly during the facility's Quality of Care meeting those in attendance are the Administrator, Director of Nursing, Social Services, Activity Director, Dietary Manager, and therapy staff. Weights were reviewed for all residents and any resident who lost 5% in 30 days the physician and dietician were notified on 4/3/12. The facility had one additional resident who had weight loss noted however this resident has been seen by the dietician and the physician is aware. 3. When the restorative aide obtains weekly weights these weights are reported to the Director of Nursing and printed by the Director of Nursing for the Quality Assurance meeting. As a strengthening of the facility's weight monitoring, the process of monitoring weights and notifying the dietician was reviewed with the Quality Assurance team.	

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F 325	Continued From page 92 identified on 03/28/12 and was determined to exist on 03/10/12. The facility was notified of the Immediate Jeopardy on 03/28/12. The facility provided a second acceptable credible Allegation of Compliance (AOC) on 03/28/12 with the facility alleging removal of the Immediate Jeopardy on 03/29/12. Immediate Jeopardy was verified to be removed on 03/29/12 as alleged prior to exiting the facility on 03/29/12 with remaining non-compliance at 42 CFR 483.25 Quality of Care, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure appropriate care and services are provided to residents. The findings include: Review of the facility's policy titled, "Nutritional Assessment", undated, revealed the Nutritional Assessment would be used by the Dietitian to assess the resident's nutritional status upon admission, and annually thereafter, and upon readmission as deemed necessary by the Dietitian. Review of the facility's "Weight Loss and Nutrition at Risk (N.A.R.) Protocol", undated, revealed if there had been an unplanned weight loss of 5 percent or more, in one months time, the resident would be placed on weekly weights and on the N.A.R. program. Further review of the protocol revealed the N.A.R. Program consists of interventions tailored to the resident individual needs to support stable or increased weight; Registered Dietitian evaluation and follow up;	F 325	This inservice was conducted by Sally Baxter, RN, on 4/3/12. For those residents requiring weekly weight monitoring a weight variance report will be printed and reviewed by the Director of Nursing. A copy will be placed in the Dietician's communication file. The process will be followed with monthly weights as well. 4. As part of the facility's ongoing Quality Assurance program at the end of each month the Director of Nursing will review all residents' records who have sustained weight loss to ensure the dietician has reviewed these residents, proper interventions have been initiated, and the physician has been notified. This process will be ongoing. 5. 4/4/12	4/4/12

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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	

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F 325	Continued From page 93 weekly review by the N.A.R. committee with detailed progress notes looking for risk factors, causal factors, and interventions and progress; and eating patterns will be reviewed and tolerance to diet. 1. Record review revealed Resident #4 was admitted to the facility on 12/23/11 with diagnoses which included Dementia, Diastolic Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Hypertension. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/30/11, revealed the facility assessed the resident as having both short and long term memory loss and as having moderate impairment in cognitive skills for decision making. Review of the Comprehensive Plan of Care, dated 01/03/12, revealed the resident had a problem of CHF related to weakness and fatigue secondary to Diastolic Heart Failure, Mild Pulmonary Hypertension, and Diastolic Dysfunction. The goal stated the resident would have clear lung sounds, and heart rate and rhythm within normal limits. The interventions included; check breath sounds and monitor and document for labored breathing, observe for any signs and symptoms of CHF including dependent edema of the legs and feet, periorbital edema, shortness of breath on exertion, dry cough, distended neck veins, weakness, increased heart rate, lethargy and monitor weight gain unrelated to intake. Review of the Physician's Progress Note, dated 01/06/12, revealed the resident was readmitted to	F 325		

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

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F 325	Continued From page 94 the facility after admission to the hospital for evaluation of Congestive Heart Failure, specifically diastolic dysfunction. Interview, on 03/19/12 at 3:30 PM, with the DON, revealed the Restorative Aide was to obtain weights and distribute copies of the weights to the nurse on duty, and was also to leave a copy of the weights in her office. She stated LPN #1 was responsible for completing the weekly Nutrition at Risk Note (NAR) Notes for residents on weekly weights. She further stated if significant weight gains were noted, LPN #1 should write a "nutritional note" which would include how much food/fluid the resident was consuming and assess the resident as needed if weight gains were significant. Interview, on 03/19/12 at 4:30 PM, with Restorative Aide (RA) #2 revealed she obtained Resident #4's weights with a lift scale and if there was a weight discrepancy of four (4) to five (5) pounds from the last weight, she would re-weigh the resident immediately and record the weight closest to the last weight obtained. She stated she put a copy of the weights in the weight book and also placed a copy under the Director of Nursing's (DON's) door. Review of the Weights and Vitals Summary Report for Resident #4 revealed a weight of 140.2 pounds on 03/05/12 and a weight of 150.4 on 03/10/12, a 10.2 pound weight gain in five (5) days. Review of the Nutrition at Risk Progress Notes (NAR) for Resident #4, dated 03/10/12 written by Licensed Practical Nurse (LPN) #1, revealed the	F 325		

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F 325	Continued From page 95 resident had a weight gain of ten (10) pounds, edema, and would continue with current Plan of Care. Interview with the DON on 03/19/12 at 3:30 PM, revealed LPN #1 should have notified the Physician of the 10.2 pound weight gain on 03/10/12 and should have assessed the resident's lungs as well as checked for pitting edema of the lower extremities. Interview with LPN #1, on 03/19/12 at 4:00 PM, revealed she was responsible for reviewing weights and monitoring weight gain or loss of five percent (5%) or more. She stated if a weight gain was noted she would observe the resident for difficulty breathing and if the resident was having difficulty she would auscultate the lungs and check for edema in the lower extremities. She stated Resident #4 was not having shortness of breath on 03/10/12 and she did not feel the need to assess the resident. She further stated she did not always communicate gains or losses to the nurses. Continued interview revealed she was unsure of who was responsible for notifying the Physician of weight gains and losses; however, it would be important to notify the Physician of this resident's weight gain since the resident had a diagnosis of Congestive Heart Failure. Interview, on 03/19/12 at 4:30 PM, with the Registered Dietician (RD), revealed she was unaware the resident had a weight gain; however should have been notified of significant weight gains or losses. She stated she was at the facility on 03/13/12 and was not notified of the weight change. Continued interview revealed the 03/05/12 to 03/10/12 weights were in her mailbox	F 325		

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F 325	Continued From page 96 and she should have reviewed them already; however, had not looked at them. She stated the DON had not discussed Resident #4's weight gain with her and a 10.2 pound weight gain was concerning. Further interview revealed the weight gain would not be related to food/fluid consumption as the resident's intake for 02/20/12 until 02/29/12 was thirty-three percent (33%) and intake for 03/09/12 until 03/19/12 was forty-five percent (45%). Interview, on 03/19/12 at 2:15 PM, with the DON and further review of the Weights and Vital Sign Summary revealed the resident's weight increased from 140.2 pounds on 03/05/12 to 150.4 pounds on 03/10/12, a 10.2 pound weight gain in five (5) days and then an additional 5.8 pound weight gain was noted on 03/19/12 when the resident's weight was recorded as 156.2 pounds, a total of 11.4% weight gain from 03/05/12 to 03/19/12; however, there was no documented evidence the Registered Dietician (RD) or Physician were notified of the significant weight gains. She further stated she entered the weights into the computer each week anger they were obtained. She stated when she entered the 03/10/12 weight into the computer on 03/12/12, she brought it to staff's attention and assumed the Physician was notified. She further stated LPN #4 called the Physician and a chest x-ray was ordered; however, LPN #4 failed to notify the Physician of the resident's weight gain. Review of Physician's Orders, dated 03/12/12, revealed a chest x-ray was ordered to rule out CHF. Review of the Radiology Interpretation for the chest x-ray completed on 03/12/12 revealed there was no stigmata of CHF. Interview with	F 325		

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F 325	Continued From page 97 LPN #4, on 03/22/12 at 9:00 AM, revealed she had notified the Physician on 03/12/12 of the residents pulmonary congestion and pedal edema and a chest x-ray was ordered. She stated she was unaware of any weight changes and had not notified the Physician of a weight gain. Review of the Nurses Notes revealed the resident was assessed daily from 03/10/12 through 03/19/12 with vital signs and oxygen saturations obtained. The Notes 3/10/12 through 03/18/12 indicated the resident's respirations were even and unlabored and the resident had edema in the lower extremities. Review of the Physician/NP/PA Communication and Progress Note, dated 03/19/12 at 11:00 AM, revealed the resident was in a wheelchair holding her/his head in her/his hands and respirations were slightly labored. Oxygen saturation was eighty-eight percent (88%) and the Physician was notified. The next entry at 11:10 AM revealed the Physician returned the call and new Physician's Orders were noted. Review of the Physician's Orders dated 03/19/12 (no time documented) revealed orders for a urinalysis and culture and sensitivity, chest x-ray, Ceftin (antibiotic medication) 500 milligrams (mg) twice a day for seven (7) days, oxygen at two liters per nasal cannula, and if oxygen saturation falls below ninety percent (90%) send to emergency room for evaluation. Review of the Nurses Notes, dated 03/19/12 at 3:00 PM, completed by LPN #3 revealed the resident was being sent to the hospital emergency room for evaluation per Physician's	F 325		

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F 325	Continued From page 98 Orders: The Note stated the residents oxygen saturation was eighty-eight percent (88%) to eighty-nine percent (89%) with oxygen at two (2) liters per nasal cannula. Further review revealed the resident had bilateral lower extremity edema and respirations were slightly labored. Interview, on 03/19/12 at 3:05 PM, with LPN #3 revealed she called the Physician at 11:00 AM because the resident's respirations were slightly labored and the resident's lower extremities were very swollen. She stated she did not notify the Physician of weight gain because she was unaware of the resident having weight gain. She further stated she received orders for a chest x-ray and oxygen at that time. Continued interview revealed, after lunch, the resident was still not feeling any better, respirations were labored and his/her oxygen saturation was only eighty-eight to eighty-nine percent (88-89%) with oxygen in place. She stated she called the Physician again and received orders to send the resident to the emergency room. Review of the Emergency Department Report dated 03/19/12 at 3:51 PM, revealed the resident had decreased breath sounds, wheezing on expiration, and had three plus (3+) pedal edema to the knees bilateral. Review of the report of the Chest X-Ray performed at the hospital, on 03/19/12 at 3:58 PM, revealed the impression was Cardiomegaly with changes of pulmonary edema and bilateral pleural effusions. Review of the Brain Natriuretic Peptide (BNP- a test used in diagnosis and assessment of severity of CHF) revealed a level of 1150 High (reference range of 0-99). Review of the Hospital Physician's Order Form dated 03/19/12 revealed the admission	F 325		

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F 325	Continued From page 99 diagnoses was CHF with Pulmonary Edema, and Hypoxia. Review of the Hospital Discharge Summary dated 03/22/12, revealed the Discharge Diagnoses included Diastolic Congestive Heart Failure with Exacerbation, and Chronic Obstructive Pulmonary Disease. The Summary stated the resident had good response to diuresis and diuresed approximately five and a half (5.5) liters of fluid before discharge. Further review revealed the resident was being transferred back to the nursing home in improved condition, to be monitored on diuretics with doses adjusted as necessary based on fluid and clinical status. Review of further Hospital Emergency Department Notes revealed the resident arrived at the Hospital Emergency Room on 03/23/12 at 3:40 PM and was discharged at 03/23/12 at 6:03 PM with a diagnosis of a Urinary Tract Infection. The resident expired at the facility on 03/24/12 at 4:00 AM. Continued 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. Interview, on 03/20/12 at 1:45 PM, with the Attending Physician/Medical Director, revealed if he had known of the weight gain he would have checked a BNP lab test. Continued interview revealed the Chest X-Ray which was ordered on 03/12/12 was not significant for CHF, possibly because the fluid was building up peripherally at	F 325		

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F 325	Continued From page 100 first, and and there was not yet a build up of pulmonary fluid. He stated the staff had made him aware of the resident being a little short of breath on 03/12/12; however, he did not remember hearing anything more "ominous". Further interview with Resident #4's Physician, on 03/27/12 at 5:00 PM, revealed he would have started the Lasix at the facility 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 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. 2. Review of the medical record revealed the facility admitted Resident #1 on 08/05/10 with diagnoses which included Atrial Fibulation, Deep Vein Thrombosis, Chronic Renal Failure, and Colectomy for Cancer. Review of the Comprehensive Plan of Care, dated 07/18/11, revealed the facility had developed a plan of care documenting the resident had potential for weight loss and poor nutritional status secondary to chronic diarrhea and history of colon cancer with interventions which included resident would be monitored by Nursing and the Dietitian for weight loss; protein supplement daily; snack of choice at bedtime; fortified foods twice daily; mighty shakes with meals; resident requested soup with lunch and supper meals (chicken noodle or vegetable soup); yogurt at 2:00 PM snack; and resident requested milk be left off his/her meal trays. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 01/09/12, revealed the facility	F 325		

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F 325	Continued From page 101 assessed Resident #1 as being alert and oriented with a BIMS score of 15 out of 15, indicating the resident was cognitively intact. The facility assessed the resident to need oversight with eating and set-up help only at meals. Review of Nutrition Progress Notes revealed the last Dietitian Assessment was completed on 01/10/12 which revealed Resident #1's weight had increased from 114 pounds (12/01/11) to 123.2 pounds (01/02/12). Further review of the assessment revealed Resident #1 requested no milk and recommendations were made to discontinue the mighty shakes due to the resident's refusals. Review of Resident #1's weekly Weight Sheet revealed Resident #1 weighed 124.2 pounds on 01/28/12. Review of facility Nurse's Notes revealed Resident #1 was admitted to the hospital from 02/02/12 through 02/07/12 related to Coumadin Toxicity. A readmission weight to the facility, obtained on 02/08/12, revealed Resident #1 weighed 118.4 pounds and had sustained a 5.8 pound/4.6 percent weight loss. The next weight was not obtained until 02/18/12, ten (10) days later, which revealed Resident #1 weighed 115.4 pounds and had sustained an additional 3 pound/2.5 percent weight loss for a total of 8.8 pounds/7 percent weight loss in less than one month. Observation, on 03/16/12 at 11:05 AM, revealed SRNA #10 obtained a weight for Resident #1 which revealed the resident weighed 114.4 pounds for a total weight loss of 9.8 pounds/7.8 percent from 01/28/12 through 03/16/12 (seven weeks). Interview with SRNA #10/Restorative	F 325		

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F 325	Continued From page 102 Aide #1, at that time, revealed weekly weights were assigned by the DON. Further interview revealed after she obtained weights, she documented weights on a piece of notebook paper, made a copy for the nurse on duty and gave the original to the DON. Continued review of the Care Plan revealed there was no evidence the facility had revised the plan of care to include Resident #1's actual weight loss with new interventions to prevent further weight loss. Further review of the medical record revealed there was no evidence the Dietitian had been notified of Resident #1's weight loss. Observation, on 03/21/12 at 12:20 PM, revealed Resident #1 was sitting up in his/her bed with his/her lunch meal tray sitting on top of the resident's bedside table adjacent to the bed. Further observation revealed Resident #1 consumed 0 % (percent) of an 8 oz (ounce) carton of Whole Milk, 4 oz bowl of Chocolate Pudding, 4 oz bowl of Black Eyed Peas, 4 oz of Sweet Potatoes, Cornbread Square, 3 oz Pork Chop, and a carton of Strawberry Mighty Shake. Additional observation revealed Resident #1 consumed 100 % of an 8 oz bowl of Chicken Noodle Soup, and 8 oz glass of Iced Tea. During an interview with Resident #1, on 03/21/12 at 12:20 PM, the resident stated the Chocolate Pudding 'was no count', meaning the pudding had no taste to the resident. Further interview revealed he/she was tired of the Strawberry Shake because he/she had received a Strawberry Shake on his/her lunch and dinner tray everyday for almost two years. Resident #1 stated he/she had never been offered any other	F 325		

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F 325	Continued From page 103 flavor other than strawberry. Resident #1 further stated the facility continued to put milk on his/her tray even though he/she had told the facility he/she didn't drink milk. Resident #1 indicated it had been awhile since the Dietitian had been in to speak with him/her about food likes/dislikes or alternate snacks. Interview with the Dietary Manager (DM), on 03/21/12 at 2:00 PM and 3:30 PM, revealed dietary 'bends over backwards to please Resident #1 but the resident was difficult to please'. Further interview revealed milk was not listed as a dislike on Resident #1's meal card and therefore he/she would be given milk at all three meals. The DM indicated she only ordered Strawberry Mighty Shakes because she had ordered other flavors but none of the residents liked the other flavors. Additional interview revealed she attended the weekly "stand up" meetings and stated they mentioned about Resident #1 coming back from the hospital and having weight issues, but she was not aware of Resident #1 having an actual weight loss and not aware of any new interventions/changes to the resident's diet. Interview with the Director of Nursing (DON)/MDS Coordinator, on 03/14/12 at 10:15 AM and 03/21/12 at 4:15 PM, revealed Resident #1's weights were discussed at the weekly Continuous Quality Improvement (CQI) meetings because she had the resident's name listed in the minutes. Further interview revealed there was no documented evidence of a Registered Dietitian (RD) evaluation and follow up, or detailed progress notes looking for risk factors, causal factors, or interventions and progress; or eating	F 325		

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F 325	Continued From page 104 patterns reviewed. The DON indicated she thought she had talked with the RD about Resident #1's weight loss, but really couldn't remember. Interview with the Registered Dietitian, on 03/22/12 at 11:30 AM, revealed she was not notified of Resident #1's admission to the hospital or weight loss after the hospitalization. She indicated she would have completed a readmission assessment, and evaluated the resident for new interventions to prevent further weight loss, such as trying a different flavored shake, or placing the resident on a therapeutic snack per the resident's preference. A review of the AOC revealed the following: On 03/28/12, to ensure appropriate care was being provided, the Executive Director (ED), the Vice President of Medical Services, and the Licensed Nursing Home Administrator (LNHA) reviewed the medical records of all residents who had a diagnosis of CHF and other residents with other chronic conditions which would require ongoing monitoring. On 03/28/12, a inservice was conducted by the LNHA at 6:00 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. The inservice included the implementation of an "Early Warning Tool" to identify and document changes in residents on a shift-by-shift basis. Weight change was included on this tool.	F 325		

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	185307		03/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP LODGE	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 325	Continued From page 105 As part of the facility's ongoing QA program, 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 plans of care were being followed, and proper care and services was being provided. These audits will be performed for ninety (90) days and then weekly thereafter. The surveyors validated the corrective action taken by the facility, prior to exit on 03/29/12, as follows: Interview with the LNHA, on 03/29/12 at 10:00 AM, revealed on 03/28/12 all medical records of residents with a diagnosis of CHF and residents with other chronic conditions which would require ongoing monitoring, were reviewed to ensure appropriate care was being provided. *Record review of the facility's audits confirmed that all records of residents with CHF and residents with chronic conditions which would require ongoing monitoring were reviewed. *Interview with the LNHA, on 03/29/12 at 10:45 AM, revealed she conducted an inservice, titled "Resident's 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.	F 325		

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F 325	Continued From page 106 *Review of the sign in sheet for the in-service revealed all staff, with the exception of LPN #7 was in attendance. Interview with LPN #2, on 03/29/12 at 9:00 AM, interview with LPN #4, on 03/29/12 at 9:15 AM, interview with LPN #1, on 03/29/12 at 9:20 AM, interview with LPN #6, on 03/29/12 at 9:30 AM, interview with MDS Nurse #3, on 03/29/12 at 9:30 AM, interview with LPN #3, on 03/29/12 at 9:40 AM, interview with LPN #5, on 03/29/12 at 9:45 AM, interview with LPN #9, on 03/29/12 at 9:50 AM, and interview with LPN #8, on 03/29/12 at 10:00 AM, revealed they had attended the in-service conducted on 03/28/12 at 5:00 PM and were knowledgeable of the information covered in the in-service. Interview with LPN #7, on 03/29/12 at 10:05 AM, revealed the LNHA had contacted her and informed her that before she was able to return to work she would have to attend an in-service related to residents with CHF. *Review of the audit entitled, "Review of Residents with CHF" on 03/29/12, revealed daily audits of the residents' charts for residents with CHF were conducted on 03/28/12, and were 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 would review on Saturday and Sunday, for the next ninety (90) days and then weekly thereafter. She further stated these audits would be reviewed daily (Monday through Friday) in the morning meetings and then every month in the QA committee meetings. Continued interview revealed Administration had participated in the creation of the audit forms and the in-services,	F 325		

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F 325	Continued From page 107 and assured staff was knowledgeable on all information covered in the In-service.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to prepare and distribute food under sanitary conditions for thirty-seven (37) of thirty-seven (37) residents. The facility failed to ensure sanitizing solutions were at the recommended sanitation concentration to prevent foodborne illness for the three (3) compartment sink as well as the sanitizing bucket which was used to clean food preparation tables and food delivery carts sent to the units. The facility failed to ensure sanitary practices of obtaining food temperatures resulting in the potential for food contamination and foodborne illness as evidenced by the failure to sanitize the thermometer with a clean alcohol wipe between taking temperatures of foods and puncturing the aluminum foil wrap with the thermometer when taking temperatures of food items. In addition, staff failed to take the temperature of pureed	F 371	F371 It is and was on the day of survey the policy of Hilltop Lodge to procure food from approved sources, as well as to store, prepare, distribute, and serve food under sanitary conditions. 1. No residents were affected by the deficient practices. 2. Fruit flies were treated prior to and following survey. All residents are monitored routinely for signs and symptoms of food-borne illness. No such illness has been noted. 3. An in-service was conducted on March 16, 2012 at 1:00p.m. with all dietary staff (cooks, dietary aides, and dietary manager) by the licensed dietician covering sanitation, proper technique for obtaining temperatures, storage of dishware, cross-contamination of clean and dirty dish areas, proper glove changing, hand hygiene, and reporting of any pests including fruit flies to the Maintenance Director.	

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STREET ADDRESS, CITY, STATE, ZIP CODE: 521 EAST HIGH STREET, P O BOX 559, OWINGSVILLE, KY 40360

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F 371	Continued From page 108 foods to determine if they were at the proper temperatures to ensure a potentially hazardous food item (ground beef) was safe for consumption. The facility failed to ensure dishware (dishes, bowls, silverware, etc.) was stored under sanitary conditions to prevent foodborne illness as evidenced by a dusty fan in the dish machine area blowing towards dishware as the equipment came out after being ran through the dish machine. In addition, staff failed to ensure they were consistently sanitizing their hands when loading dirty dishware into the dish machine to emptying dishware as it came out of the dish machine. The facility also failed to ensure proper glove changing and hand washing during resident meal service. The facility failed to ensure proper food storage as evidenced by food for the next meal stored uncovered in the freezer. The facility failed to address the potential transmission of micro-organisms as evidenced by fruit flies observed in the kitchen around the trash can and also landing on the food preparation tables. The findings include: Review of the facility's policy entitled 'Sanitation', undated, revealed training was provided to appropriate personnel regarding correct procedure, cleaning agents and frequency of cleaning. Further review of the policy revealed cleaning schedules were established to assign specific tasks to scheduled employees on a daily,weekly and monthly basis. Review of the Department of Public Health Inspection, dated 12/08/11, revealed areas of concern included chipped and rusty metal	F 371	4. As part of the facility's ongoing Quality Assurance program the Dietary Supervisor (Monday through Friday) and cook on (Saturday and Sunday) will check the sanitation solution for proper concentrations daily at various times. In addition, she will monitor the staff taking food temperatures to ensure proper technique is used when cleaning thermometers with alcohol between each food tested. This practice will continue indefinitely. As part of the facility's Quality Assurance program the Dietician will audit how food is stored, prepared, distributed, and served on a monthly basis and report any deviations to the administrator who will forward these on to the Quality Assurance Committee. This practice will continue indefinitely. 5. 3/30/12	3/30/12

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F 371	Continued From page 109 drawers/vent hoods in poor repair and dusty fans. The Health Department scored the facility at 95/100 %. Review of the facility's handout entitled, "Kitchen/Food Service Observation", in-serviced to kitchen employees, on 01/30/12, revealed under Dinnerware Sanitization and Storage if explicit manufacturer instructions were not provided, the recommended sanitation concentration for chlorine was fifty-one-hundred (50-100) parts per million (ppm) minimum ten (10) second contact time. Review of the facility's 'Dietary Report & Monthly Quality assurance Audit', dated 01/30/12, revealed staff did not document meal temperatures of the observed lunch meal service. Additional review of the audit, under the 'Quality Assurance Compliance Summary, Foodborne Illness Risk Factors/Sanitation Audit' revealed a score of 87/100 percent. Items not meeting compliance on the audit included glasses not covered in the freezer, dust on the fan in the dish machine area, work drawers with chipped paint, and cross contamination observed when going from the "clean" side of the dish machine to the "dirty" side of the dish machine. Review of the facility's policy entitled 'Pots and Pans', undated, revealed for Sink Number III (Sanitizing Sink), prepare a solution of the facility approved sanitizer and hot water. Review of the facility's 'Tray Line and Meal Service Temperatures' policy, undated, revealed food temperatures would be taken prior to the start of each meal at the service line by the Cook	F 371		

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F 371	Continued From page 110 on duty or the Dietary Manager and recorded on the temperature checklist. Further review of the policy revealed thermometers must be tested for accuracy of hot foods by immersing in boiling water of 212 degrees Farenheit (F) and checking for a reading of 212 degrees; and immersing in a 50/50 ice and water slush until the reading stabilizes test accuracy for cold foods and adjust the unit to 32 degrees F. Additional review of the policy revealed the thermometer would be sanitized between taking food's temperature by cleaning with alcohol swab. Review of the facility's 'Hand Hygiene' policy from the Infection Control Manual, dated 2007, revealed when decontaminating hands with an alcohol-based hand rub, apply product to palm of hand and rub hands together, covering all surfaces of hands and fingers until hands are dry. Observation, on 03/13/12 at 10:20 AM, revealed the freezer had ice cream scooped into individual bowls stored uncovered. Interview with Dietary Manager, on 03/14/12 at 9:50 AM, revealed they were supposed to cover the ice cream to prevent anything from dripping down onto the ice cream, per facility policy. Observation, on 03/13/12 at 10:48 AM, revealed a sanitizing bucket was located next to the three compartment sink in the dish machine area. Interview with the Dietary Manager, at that time, revealed they could not test the sanitizing bucket because they did not have a test strip available to perform the test. An observation with the Dietary Manager, on 03/13/12 at 5:15 PM, revealed no reaction on the	F 371		

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F 371	Continued From page 111 strip when a test of the sanitizing bucket solution was performed using Blue Ridge Chlorine Test Strip. Interview with the Dietary Manager, on 03/13/12 at 5:15 PM, regarding the process for replacing and testing the sanitizing solution in the sanitation bucket revealed they tested the solution after replacing the solution. She stated without testing you can't determine if you have the proper amount of bleach solution. She further stated the results of the test were not recorded. Further interview revealed, they replaced the solution after breakfast, lunch, and dinner. Continued interview with the Dietary Manager revealed if the test strip did not react it must not have had the correct amount of bleach. Further interview revealed Dietary Cook #2 had replaced the solution after lunch. Interview, on 03/13/12 at 5:20 PM, with Cook #2 revealed she replaced the sanitizer bucket solution after lunch, but did not know how much bleach was supposed to be put in the bucket so she only dumped a little bleach into the bucket. She indicated she did not normally replace the solution. Further interview, at 6:50 PM, revealed she was not trained on the proper method ensuring the sanitizing bucket was at the proper concentration. Additional interview revealed they were not told an amount of bleach to put into the sanitizing bucket. Observation, on 03/13/12 at 5:25 PM, revealed facility staff emptied the sanitizing bucket and re-mixed the sanitizing solution by pouring chlorine bleach into the bucket with water. The solution was then tested using Hydrion Chlorine	F 371		

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

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F 371	Continued From page 112 Test Paper, by Dietary Aide #1, who normally did the testing of the sanitizing bucket and the three compartment sink, and no reaction on the test strip was observed. Further observation revealed, the sanitizing bucket was emptied and again re-mixed using chlorine bleach and water, by Dietary Aide #1. Interview, on 03/13/12 at 5:25 PM, with Dietary Aide #1 revealed the test strip reading was two-hundred (200) ppm. When asked if this was the proper sanitizing solution, she stated she was unsure of the proper sanitation level required for the solution, and all she knew was the test strip was supposed to turn purple but didn't know what that meant. Further interview, on 03/13/12 at 6:50 PM revealed, they were just taught to pour bleach in the bucket and were good to go. Additional interview revealed no one taught her anything about the sanitizing bucket and she did not know she was supposed to test the bucket on a regular basis. Telephone Interview, on 03/13/12 at 8:00 PM, with Dietary Aide #3 revealed she put a little bit of bleach in the sanitation bucket every morning and thought it was about a half (1/2) cup. Further interview revealed she did not test the sanitation bucket and only tested the three compartment sink. Additional interview revealed, she did not recall getting trained on the appropriate use of the sanitizing bucket as far as how much solution and that it should be tested. Interview with the Dietitian, on 03/13/12 at 5:30 PM, revealed staff was supposed to mix a teaspoon of chlorine bleach with the water and the proper sanitizing solution should be between	F 371		

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F 371	Continued From page 113 fifty (50) - one-hundred (100) ppm after a ten (10) second contact time with the test strip. 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. Observation, on 03/14/12 at 4:00 PM, revealed Dietary Aide #1 performed the facility's process for preparation of the three compartment sink for rinse and sanitation by mixing hot water with the quaternary sanitizing solution. Further observation revealed the temperature of the sink solution was taken with a digital thermometer and read 116.1 degrees Farenheit. She tested the solution with a Hydrion QT-10 Quaternary control strip. Interview with Dietary Aide #1, at that time, revealed the reading was greater than 400 ppm. 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	F 371		

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F 371	Continued From page 114 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 Dietary Manager, on 03/14/12 at 4:00 PM, revealed the facility started using the company (Premier Medical Partner) to provide the automated sanitation dispenser about a month ago. Further interview revealed she thought the water temperature to mix with the sanitizer should be about one-hundred (100) degrees. Additional interview revealed she did not get trained by the company on using the product and therefore did not train her employees. Interview with the representative of Premier Medical Partner, on 03/15/12 at 3:45 PM, revealed the sanitization solution used, Sure Guard Ultimate, in the three compartment has a range of effectiveness between one-hundred and fifty (150) ppm to four hundred (400) ppm. Further interview revealed the solution should be run with cold water to stabilize the product and the sanitizer works best at room temperature water. Further interview revealed, if hot water is mixed with the solution it could read high when tested with the test strip. Observation during lunch meal service, on 03/15/12 at 11:20 AM, revealed Cook #1, touched the stove knob with her gloved hand and readjusted her glasses before continuing to plate food. Interview with Dietary Manger, on 03/16/12 at 10:12 AM, revealed Cook #1 should not have touched her glasses and should have washed her	F 371		

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F 371	Continued From page 115 hands afterward. The Dietary Manger indicated the cook should have used a paper towel to touch the stove knob or washed her hands to prevent cross contamination. Observation, on 03/15/12 at 11:37 AM, revealed Dietary Aide #3 put a tray of dirty dishes into the dishwasher, then changed gloves and touched items in the clean dish tray and did not sanitize her hands prior to putting on a new pair of gloves. Observation of staff taking food item temperatures, on 03/15/12 at 11:05 AM and at 11:50 AM, revealed Cook #1 took temperatures of the following food items: Mac and Cheese, Diabetic Baked Apples, Meatloaf, Regular Baked Apples, and Fried Okra using only one (1) alcohol pad to clean the thermometer each time between the items. In addition, when taking temperature of the Baked Apples, Meatloaf, and Fried Okra, Cook #1 punctured the tin foil covering the items to take the temperature. Further observation revealed the facility failed to take take temperatures of the pureed food items and the thermometer was not tested for accuracy by placing the thermometer in ice water or boiling water, per facility policy. Interview with the Dietary Manager, on 03/15/12 at 12:45 PM, revealed Cook #1 did not obtain the pureed food temperatures but she should have to ensure the proper temperature. Interview with Cook #1, on 03/16/12 at 10:10 AM, revealed she had used one (1) alcohol pad to disinfect the thermometer between taking temperatures of the different food items. She stated her mind went blank and she was	F 371		

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

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F 371	Continued From page 116 supposed to use a new alcohol pad each time to disinfect. She stated she usually turned back the foil prior to taking the temperature. Interview with the Dietary Manager, on 03/16/12 at 10:12 AM, revealed staff was supposed to turn the foil back and then take the temperature with the thermometer to ensure aluminum foil didn't go into the food and to ensure the thermometer was at the proper depth to obtain an accurate reading. Additional interview revealed the process to properly disinfect the thermometer was to use a new alcohol pad each time. Observation, on 03/16/12 at 10:15 AM, revealed some of the same unsanitary conditions were present as noted from the health department inspection, conducted on 12/08/11. These observations included an accumulation of dust on the fan located in the dish machine area. Further observation revealed the fan was blowing towards the dish machine where dishes had just come out of the dish machine. Additional observation revealed two drawers in the kitchen which contained spatulas and serving spoons were chipped and rusty. Observation of the hood above the stove revealed the hood vents were rusty. Observation of the facility's cleaning list located on the back of the kitchen entrance door, on 03/16/12 at 10:25 AM, revealed employees names were listed with what area/equipment they were responsible for cleaning. The list did not direct employees as to when the cleaning should be performed other than wipe the microwave out everyday. Further review of the cleaning list revealed it listed Dietary Aide #3 as responsible for cleaning the dish room, but did not specifically	F 371		

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F 371	Continued From page 117 list the fan in the dish room. Interview with the Dietary Manager, on 03/16/12 at 10:25 AM, revealed she had developed the cleaning list per person with the area that was supposed to be cleaned because she felt like it was more effective. Further interview revealed she needed to have a more specific cleaning schedule to assign specific tasks to scheduled employees on a daily, weekly and monthly basis, per facility policy, as well as to be able to follow up and monitor after the employee had checked off on the list that they had cleaned the assigned equipment/area. Observation, on 03/17/12 at 3:55 PM, revealed Dietary Aide #1 had just wiped the food service carts with a cloth that had been in the sanitizing bucket. Dietary Aide #1 tested sink III (sanitizing sink) by inserting a Chlorine Test Strip made by Hydrion, dated 09/04/11 as the delivery date, into the sink and obtained a level of 200 ppm. Dietary Aide #1 questioned the surveyor at that time if she should test the sanitizing bucket because she had obtained the sanitizing solution from the three compartment sink and it would probably register the same amount. Observation revealed Dietary Aide #1 inserted a test strip into the sanitizer bucket and it registered 0 ppm. She attempted a second time and it did not register. Dietary Aide #1 then poured the liquid out of the sanitizer bucket and dipped the bucket into the three compartment sink. She proceeded to test the sanitizer bucket and obtained a level of 200 ppm. Interview with Dietary Aide #1, on 03/17/12 at 4:05 PM, revealed the sanitizing solutions were at	F 371		

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F 371	Continued From page 118 the appropriate level because she had been in-serviced yesterday (03/16/12 at 1:00 PM) that the appropriate level should be between 150 ppm-400 ppm. She indicated she was not shown specifically which test strip to use. Interview with the DM, on 03/17/12 at 4:50 PM, revealed Dietary Aide #1 used the test strips the representative had left when he installed the quaternary sanitizing solution about a month ago. Interview and observation with the Consultant Nurse, on 03/17/12 at 5:05 PM, revealed there were two dispensers of test strips in the kitchen that looked very similar. One type of test strip was a chlorine test strip and the other type was for the quaternary solution. The Consultant Nurse stated they were only supposed to use the chlorine test strips when they used a chlorine sanitizing solution, if there was a noro-virus, because bleach is the only thing that would kill that virus. Further interview revealed there had not been any out break of the noro-virus. Observation, on 03/17/12 at 4:10 PM, revealed a fruit fly was flying around the preparation table in the middle of the kitchen. Further observation revealed the fruit fly landed on the preparation table and Cook # 2 swiped the fruit fly from the table. Observation, on 03/20/12 at 9:45 AM, revealed several fruit flies were flying around a large trash can with a lid outside of the dish machine area in the kitchen. Interview with the Dietary Manager and Dietary Aide # 2, at that time revealed the fruit flies had been in the kitchen for about three to four weeks. Further interview revealed the "bug	F 371		

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F 371	Continued From page 119 man" had been at the facility about a week ago and they were told to make sure the floor mats in the dish machine area were put up to dry at night. Observation with the Dietary Manger, on 03/20/12 from 9:10 AM through 9:45 AM, revealed Dietary Aide #3 did not appropriately sanitize her hands between loading dirty dishware into the dishwasher and unloading the dishware as it came out of the dish washer. Dietary Aide #3 placed dirty dishware into the dish machine rack with her gloved hand. She then sprayed the eating equipment on the rack with water from a hose above the rack. Water from the dirty equipment was observed to splash onto the sides of the rack. Dietary Aide #1 took off her gloves, put alcohol gel in the palm of her hand and quickly rubbed the gel through her hands but was not observed to get the gel between her fingers. She immediately put a new pair of gloves on with her hands that were still wet with the gel, and did not ensure her hands were dry or that she had rubbed all areas of her hands with the gel per facility infection control policy. Dietary Aide #3 then pushed the dirty rack into the dish machine by placing a gloved hand on each side of the rack. She then took the dish rack that had been run through the dishwasher with the same gloved hand and proceeded to unload the dishes from the rack to a drying rack. Interview with the Dietary Manager, on 03/20/12 at 9:50 AM, revealed she could see where Dietary Aide #3 could cross contaminate by not properly sanitizing her hands when going from the "clean' side to the "dirty" side of the dish machine. Additional interview revealed it would be difficult to explain this to Dietary Aide #3 as she spoke	F 371		

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F 371	Continued From page 120 little English. Further interview revealed it was a tight time frame between breakfast and lunch and with having only one person in the dish machine area it made it difficult to wait until your hands were dry prior to putting new gloves on or to even change gloves so frequently.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F431 It is and was on the day of survey the policy of Hilltop Lodge to obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 1. The medication carts have been reorganized to ensure separation of internal and external medications. The cart was reorganized on 3/30/12 by the consultant pharmacist. 2. All medications are being properly labeled and stored. 3. An in-service was conducted with licensed staff by the consulting pharmacist on 3/30/12 concerning medication labeling and storage. Monthly the consultant pharmacist	

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F 431	Continued From page 121 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure proper storage of medication as evidenced by eye drops located in the same compartment as oral medications in the medication cart. Also the Shower Room cabinet contained a tube of Sensi-Care (protective barrier cream with zinc oxide based to provide barrier guard for high risk, fragile, weepy, denuded or sensitive skin to help manage/prevent irritation due to urine and fecal incontinence) with a pharmacy printed resident identification label and two (2) tubes of Baza-Protect (Zinc oxide and dimethicone with petrolatum; natural vitamins A, D & E. Provides everyday wetness protection and aids in the prevention and treatment of incontinent collection garment/diaper or pads dermatitis) with a pharmacy printed resident identification label on one (1) of the tubes, and a tube of double antibiotic ointment which had no resident identification label. Observation of the Medication Room revealed the treatment cart with a bottle of hydrogen peroxide which was opened and undated. The findings include: Review of the facility's policy titled, "Equipment/Supply Storage", dated 01/09/03, revealed drugs and biologicals supplies must be stored in the containers in which they were received; and are stored in locked compartments.	F 431	will review all medication carts and medication storage areas to ensure proper storage and labeling. At least quarterly the Director of Nursing will audit the above areas. 4. As part of the facility's ongoing Quality Assurance program the pharmacy representative will audit the medication carts monthly. This audit will be made part of the facility's Quality Assurance Program and will be ongoing. 5. 4/1/12	4/1/12

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F 431	Continued From page 122 Only authorized personnel should have access to the keys. It shall be the Department Supervisor's responsibility to assure that proper storage procedures were maintained. Review of the facility's policy titled, "Medication Storage in the Facility", undated, revealed medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Orally administered medications should be kept separated from externally used medications. Observation, on 03/13/12 at 10:40 AM, revealed the Shower Room on the long hall had a cabinet on the wall which was unlocked and contained a tube of Sensi-Care cream, two (2) tubes of Baza-Protect with a pharmacy printed resident identification label on one (1) of the tubes, and a tube of double antibiotic ointment which had no resident identification label. Interview with the Director of Nursing (DON), who was in the shower room at the time, revealed the cabinet should have been locked and the Sensi-Care cream, Baza Protect, and double antibiotic ointment should have been stored in the treatment cart. Further observation, on 03/15/12 at 9:30 AM, of the medication room revealed an opened undated bottle of hydrogen peroxide on the treatment cart. Interview at that time, with Licensed Practical Nurse (LPN) #6, revealed the bottle should have been dated when opened and she needed to throw it away. Observation, on 03/15/12 at 10:00 AM, revealed two (2) bottles of Patanol ophthalmic solution, a bottle of Opticlear eye drops, and two (2) bottles of Gentamicin Sulfate ophthalmic solution were in	F 431		

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F 431	Continued From page 123 the same compartment in the medication drawer as oral medications. Interview, on 03/15/12 at 10:00 AM, with LPN #6 revealed the eye drops and oral medications should not have been in the same drawer. Further interview, on 03/23/12 at 4:30 PM, with the DON revealed the facility had some wandering residents who were ambulatory and toiletries, medications, and chemicals should not be left in an open area accessible to residents. She further stated, eye drops should be in a separate compartment from oral medications in the medication drawer.	F 431		
F 441 SS=J	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F441 It is and was on the day of survey the policy of Hilltop Lodge to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment that helps to prevent the development and transmission of disease and infection. A. Infection Control Practices— It is and was on the days of survey the policy of Hilltop Lodge to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. This program investigates, controls, and prevents infections in the facility. Policies	

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F 441	Continued From page 124 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policy, it was determined the facility failed 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. 1. 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. In addition, the	F 441	and procedures are developed to guide staff in practices to prevent spread of infections. All nursing practices are to uphold minimal risks of infection to residents and personnel, by monitoring appropriate control measures, identifying and correcting problems related to infection prevention practices, and maintaining compliance with state and federal regulations. Yearly mandatory inservices regarding infection control have been completed for all staff, as well as stand-up meetings for nursing staff on a routine basis related to infection control and proper hand-washing. 1. No residents have been affected by the facility's infection control practices. Upon return of the resident with infection to the facility, the roommate was encouraged to change rooms. Due to unavailability of a private room at that time, the roommate was educated to the potential risks and refused to move from this room. On March 15, 2012	

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F 441	Continued From page 125 resident was not place in contact isolation until 02/29/12. 2. The facility failed to ensure residents who were immunosuppressed were not sharing rooms with residents who were diagnosed with multi-drug resistant organisms. 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. In addition, the facility failed to ensure staff was knowledgeable related to hand hygiene for residents in Contact Isolation as evidenced by the observation of staff exiting Resident #8's room to wash hands in the mens/women's bathroom. Also, the facility failed to ensure staff were decontaminating Resident #8's bathroom sink and toilet to prevent Resident #5 and the other residents who utilized the bathroom from being contaminated after staff emptied Resident #8's colostomy bag into a urinal, then into the toilet in the residents' bathroom, then rinsed the urinal in the sink. 3. The facility failed to ensure follow up with Resident #6's Physician regarding treatment after a sputum culture completed on 03/01/12 identified growth of the organism, Methicillin Resistant Staphylococcus Aureus (MRSA). 4. The facility failed to ensure staff followed Contact Precautions for Resident #6 who had been identified with MRSA of the sputum and was in contact isolation. Observations revealed the potential for contamination of clothing when staff	F 441	at approximately 11:45pm the Executive Director spoke with the resident involved via cordless phone to again explain potential risks. The resident at this time still refused to make any room changes. The staff have been instructed to clean all hard surfaces (toilet, sink, and sink handles) with Virex/Oxivir TB and allow one minute wet time before wiping clean. The Virex/Oxivir TB is kept in a locked metal box under the residents' sink in the rooms of those that are in isolation. Staff members (nursing, housekeeping, and therapy) have been observed and deemed competent by the Director of Nursing, or charge nurse, before providing care to residents in isolation. The resident with past head lice was treated and monitored. There was no infection related to this issue. Medications and equipment used for the resident with lice was stored in sanitary conditions. Resident #8's physician was notified of the results of the urinalysis on 2/17/12 which indicated an urinary tract infection. An order was obtained for Ceftin 500mg twice per day for seven days and to obtain another urinalysis in ten (10) days.	

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F 441	Continued From page 126 sat on Resident #6's bed without adequate coverage of the Personal Protective Equipment (PPE). Additional observation revealed staff exited Resident #6's room without washing their hands prior to leaving the room. In addition, interviews with staff revealed Resident #6 had Vancomycin Resistant Enterococcus (VRE) of the urine; however, staff emptied Resident #6's urinary catheter bag into a urinal, then into the toilet in the resident's bathroom, then rinsed the urinal in the sink. The facility failed to ensure staff decontaminated the sink or toilet following these practices even though the bathrooms were utilized by other residents. 5. 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. In addition, the facility failed to implement and document actions to resolve the related problems after a trend of a total of ten (10) Urinary Tract Infections was identified in January 2012 and February 2012. In addition, the facility failed to have an effective process to provide oversight related to ensuring employee hand hygiene, pest control, waste disposal, and handling and/or processing linens to prevent the spread of infection. 6. The facility failed to ensure proper infection control technique related to a skin assessment and dressing change for Resident #3, and a skin assessment for Resident #1. In addition, the facility failed to ensure proper hand hygiene during medication administration. Observation revealed a staff member failed to wash her hands after administration of medications to Resident #7 and prior to administration of medications to	F 441	On 2/18/12 the final sensitivity report from the 2/16/12 urinalysis was obtained. The physician was notified with no new orders given, therefore there was not a delay in antibiotic therapy. Resident #6 did not experience any adverse effects related to the therapist alleged failure with isolation procedures. No other residents have contracted MRSA. Resident #3, #1, and #7 did not experience any negative outcomes to the alleged failure with handwashing. Resident #4 had two episodes of head lice which were immediately identified and treated by staff. Resident #2 has no ill affect related to the alleged touching of the feeding syringe. 2. All residents are monitored for signs and symptoms of infection on an ongoing basis utilizing the Interact II program, which includes the early warning tool that is utilized by all staff to identify any change in	

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F 441	Continued From page 127 Unsampled Resident A. 7. The facility failed to ensure all infections were tracked and trended. Resident #4 had two (2) episodes of Pediculosis (head lice) which the facility failed to track and trend. 8. The facility failed to ensure proper infection control technique for residents who were being orally fed per syringe. Observation of a staff member feeding Resident #2 revealed the staff member touching the tip of the 10 millimeter (mm) syringe with her bare hands and then inserting the syringe into the resident's drink. 9. The facility failed to ensure residents received Annual Tuberculin Skin Tests. Resident #1's admission Tuberculin Skin Test was completed on 08/07/10. However, the facility failed to complete the annual follow-up TB skin test until 02/07/12 which was six (6) months past the due date. 10. The facility failed to ensure personnel handled, stored, processed, and transported linens in order to prevent the spread of infection. Interviews with laundry staff revealed they were not trained or knowledgeable in how to take washing machine temperatures and therefore were not obtaining and recording the washing machine temperatures. 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 Farenheit to be effective in killing multiple organisms including Methicillin Resistant Staphylococcus Aureus(MRSA). In addition,	F 441	residents' condition, including signs and symptoms of infection. Any resident requiring isolation will not share rooms with any other resident. 3. An inservice was conducted on March 16, 2012 by Stacey Richardson, RN, BSN, LNHA and Marcia Stamm, RN reviewing isolation precautions, VRE, MRSA, donning and disrobing of PPE, hand-washing, cleaning the environmental surfaces (sink, commode, and faucets) with Virex/Oxivir TB and a contact time of one minute prior to wiping. The inservice reviewed proper handwashing technique, feeding technique, TB skin testing, and storage of resident equipment and biologicals. Staff in attendance of this inservice were all nursing staff (with the exception of one LPN who was on vacation, she will be inserviced and competency tested prior to returning to work), housekeeping, maintenance, administrative staff, and contracted therapy staff. Physicians will continue to be notified of resident conditions requiring antibiotic treatment and document this notification. It should be noted that the facility tracks and trends	

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	185307		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

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F 441	Continued From page 128 there was no separation between the clean and dirty laundry areas causing the potential for cross contamination. 11. The facility failed to ensure there was not an accumulation of Biohazard Medical Waste. Observation of the Soiled Utility Room revealed an accumulation of seven (7) large boxes of biohazard medical waste. In addition, the facility failed to ensure biohazard waste was segregated from cleaning equipment and supplies. Also, the facility failed to ensure the Biohazard Medical Waste was contained in an area which was free of pests. Flying insects were observed 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). 12. The facility failed to ensure the building was free of pests. Observation revealed the fruit flies were in the kitchen flying around the large garbage can outside the dish machine area in the kitchen and landed on the food preparation table adjacent to the trash can. Additionally, observation revealed fruit flies in the employee break room and the dining room. Interviews with staff revealed the fruit flies had been in the facility for months. However, there was no documented evidence the pest control program had targeted the infestation of fruit flies until after the start of the Recertification Survey on 03/13/12. 13. The facility failed to ensure proper labeling and storage of urinals, wash basins, emesis basis, and incontinence products to prevent the spread of infection. Observation during	F 441	infections and will include the causative organism to the tracking and trending. 4. As part of the facility's ongoing Quality Assurance program the Director of Nursing or charge nurse will monitor hand-washing, donning and disrobing of PPE, cleaning of hard surfaces, and a wet time for cleaning at least once per day for the next 90 days and then weekly thereafter if a resident requires isolation. As part of the facility's ongoing Quality Assurance program the Director of Nursing will monitor handwashing during resident care monthly on various shifts. All infection control audits will be ongoing. Any issues identified will be reviewed with the Administrator and Medical Director. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, Dietary Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Activity Director and Social Services, will in turn develop an action plan for any identified issue noted above. 5. 3/30/12	3/30/12

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F 441	Continued From page 129 environmental tour revealed the bathroom in Semi-private Resident Room D1-7 contained two (2) urinals, undated and unlabeled, suspended from the trash can. In addition, a washbasin was located on the bathroom floor. Semi-private Room D3-3 had an unlabeled emesis basis located on the back of the toilet. Observation in the Hall Storage Room Closet revealed two (2) packages of Attends (disposable incontinence care product) located on the floor. 14. The facility failed to ensure the crash carts contents were not expired and the integrity of the contents was not compromised. Observation revealed suction tubing with an expiration date of 2011, a face mask which was not packaged and two (2) oxygen rebreather masks had tears in the packaging. 15. The facility failed to ensure mechanical lift slings and Tena Pads were properly stored in order to prevent the spread of infection. Observation on initial tour revealed "lift slings" which had been laundered and folded and placed on the toilet located in the shower room. Also, in the shower room floor was noted a box of Tena Pads (disposable underwear). 16. The facility failed to ensure proper storage of medication vials, and specimen cups, and failed to ensure biologicals were dated when opened. In addition, the facility failed to ensure expired supplies were not accessible for resident use. Observation revealed a box of sodium chloride vials and a box of urine collection specimen containers located on the floor in the medication room. Further observation revealed expired/outdated intravenous tubing in a drawer	F 441	B. Dietary Services— The facility stores, prepares, distributes, and serves food under sanitary conditions. The dietary department sanitizes the prep tables using chemical solutions in accordance to the manufacturer's instructions. For example, Quaternary Sanitizing product with a minimum range of 150-200ppm and 10 seconds of contact time per manufacturer's guidelines. An inservice was conducted on March 16, 2012 at 1:00pm by the facility's licensed dietician. During the inservice, sanitation of prep tables and preparation of the sanitation solutions as well as testing of these solutions and the proper procedure for testing food temperatures were reviewed with all dietary staff. 1. No residents have been adversely affected by the alleged dietary practices. 2. All residents are monitored routinely for signs and symptoms of food-borne illness. No such illness has been noted.	

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F 441	Continued From page 130 and a bottle of Hydrogen Peroxide which was undated and open on top of the treatment cart. 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 02/16/12. 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. Immediate Jeopardy was verified 03/27/12 to be removed on 03/17/12 prior to exiting with the facility on 03/29/12 with remaining non-compliance at 42 CFR 483.65 Infection Control, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure a safe, sanitary and comfortable environment and to prevent the development and transmission of disease. The findings include: 1. Review of the facility's policy, "Changes in a Resident's Condition or Status", dated 01/09/03, revealed it was the policy of the facility to notify the attending physician of changes in the resident's condition and/or status. The policy further stated Nursing Services was responsible for notifying the resident's attending physician when there was a need to alter the resident's treatment significantly or if deemed necessary or	F 441	3. An inservice was conducted on March 16, 2012 at 1:00pm with all dietary staff (cooks, dietary aides, and dietary manager) by the licensed dietician covering sanitation (mixing of sanitizers and testing for proper concentration of sanitizing solutions), as well as proper testing of food temperatures and cleaning the thermometer between testing each food. Competency check-offs, related to the above inservice, were completed by all dietary staff and conducted by the dietary manager. 4. As part of the facility's ongoing quality assurance program the dietary supervisor (Monday through Friday) and cook (Saturday and Sunday) will check the sanitization solution for proper concentrations daily at various times. In addition, she 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. The registered dietician will also audit these processes on a monthly basis. Any issues identified will be reviewed with the	

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F 441	Continued From page 131 appropriate in the best interests of the resident. Review of the facility's protocol, undated, for Vancomycin-Resistant Enterococcus [(VRE)-specific species of bacteria which are known to be resistant to Vancomycin, an antibiotic used to treat infections] infections, revealed residents with a known or suspected serious illness easily transmitted such as VRE should be placed in Contact Precautions because VRE may be passed from person to person by caregivers following contact with an infected resident or contaminated surface. Record review revealed the facility admitted Resident #8 on 01/06/12 with diagnoses which included Chronic Obstructive Pulmonary Disease, Chronic Renal Insufficiency, Dementia and Stroke. Review of the Minimum Data Set (MDS) Assessment, dated 01/13/12, revealed the facility assessed the resident to have cognitive loss. Continued review of the MDS revealed the facility conducted a Brief Interview of Mental Status (BIMS) and determined Resident #8 had a problem with short term memory and some difficulty making decisions regarding tasks of daily life. Review of the Comprehensive Care Plan, dated 1/17/12, revealed Resident #8 was identified to have Bladder Incontinence. Interventions included monitor for signs and symptoms of urinary tract infection and prompted toileting. Interview, on 03/17/12 at 4:48 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #8	F 441	Administrator and Medical Director. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, Dietary Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Activity Director and Social Services, will in turn develop an action plan for any identified issue noted above. 5. 3/30/12	3/30/12

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F 441	Continued From page 132 was monitored for signs and symptoms of urinary tract infections which included monitoring for a change in vitals signs, mental status or physical change in the characteristics of the resident's urine such as cloudiness or odor. Review of the Bladder Pattern Forms, dated January and February 2012, and interview, on 3/23/12 at 3:15 PM, with Restorative Aide (RA) #2, revealed Resident #8 was on a prompted toileting scheduling and was both continent and incontinent of urine during those dates. Review of the Interact Nurses Notes revealed Resident #8 exhibited increased confusion on 02/15/12. Continued review revealed the Physician ordered a urinalysis to be obtained on Resident #8 with culture (culture is done to find out what kind of organism/bacteria is causing an illness or infection) and sensitivity [sensitivity (susceptibility) test checks to see what kind of medicine, such as an antibiotic, will work best to treat the illness or infection]. Review of Resident #8's laboratory reports revealed a urine specimen was collected on 02/16/12 with preliminary results faxed to the facility on 02/17/12 noting there were two (2) organisms cultured, report status noted to be "Partial". Continued review of Resident #8's medical record revealed the Physician was notified of the results and treatment of a single antibiotic, Ceftin, was ordered. Review of Resident #8's laboratory reports revealed on 02/18/12 the facility received the "Final" report of the urinalysis with the two (2) organisms identified and the sensitivities for the	F 441	C. Physical Environment— It is and was on the days of survey the policy of Hilltop Lodge to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility currently has two residents who are in isolation and the facility contracts with two medical waste providers. The facility had pick-ups on March 7th, 16th, and again on the 21st of 2012. The waste was bagged and boxed according to state and federal guidelines. Some fruit flies noted in the facility; however the facility has a pesticide contact with Guarantee Pest Control. The exterminator visited on the first visit (3/13/12) and they could not determine the source of the fruit flies, however on the second visit (3/16/12) the source of the fruit flies was identified. This area was immediately treated with an enzyme which has killed these flies. 1. No residents were affected by these practices.	

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F 441	Continued From page 133 organisms reported. Organism #2 was noted to be "VRE" for which the antibiotic, Ceftin, was not listed as a treatment choice by listing values of the susceptibility to inhibit/kill the organism. Interview, on 03/17/12 at 10:00 AM, with LPN #1 revealed she had notified the Physician of the laboratory findings on 02/18/12 and would have given him the information listed on the laboratory report including the organisms identified. Interview, on 03/20/12 at 2:10 PM, with Resident #8's Physician revealed he could not recall being notified on 02/18/12 of the abnormal laboratory findings. He further stated the resident would have been started on an additional antibiotic to treat VRE on 02/18/12 when the organism was first identified to be present in the resident's urine. In addition the resident would have been placed in Contact Isolation on 02/18/12 instead of eleven (11) days later when the follow-up urinalysis was completed and he was notified of "VRE" in Resident #8's urine. However, record review revealed on 02/22/12, the Physician had signed and written "NNO" (no new orders), on the laboratory report which identified Resident #8 was on the antibiotic, Ceftin, which was not shown to be an effective treatment for organism #2, "VRE", identified on the report. Continued interview with Resident #8's Physician revealed "he didn't have a good idea" why treatment wasn't started on the 02/22/12 when he reviewed, dated and signed the laboratory results. Record review revealed Resident #8 had a repeat urinalysis completed on 02/27/12 with a culture and sensitivity reported as "Final" on 02/29/12. The culture identified two organisms with	F 441	2. All medical wastes are bagged, boxed, and stored according to state and federal guidelines. All fruit flies will be exterminated. 3. The storage area has been re-arranged. All clean products have been covered to prevent contamination. Maintenance will continue to monitor the facility for fruit flies and treat any area with the enzyme provided. 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. The housekeeping supervisor will daily (Monday through 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 (10) days, the maintenance director will monitor the building for fruit flies. Treatment will be initiated as problems are noted.	

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F 441	Continued From page 134 Organism #2 identified as "VRE". Record review of Physician Orders, dated 02/29/12, revealed orders to initiate two medications as part of the treatment regime for Resident #8's urinary tract infection with one antibiotic noted specifically targeted to treat "Vancomycin-resistant" organism. In addition, the Physician Orders revealed an order for Contact Protocol Precautions dated 02/29/12. Interview, on 03/20/12 at 10:30 AM, with the DON/ICN revealed the facility should have identified Resident #8 was not on the appropriate antibiotic to treat VRE when the urine results reported out as a "Final" report on 02/18/12. She stated, the facility should have notified the Physician and discussed the need to alter treatment to effectively treat the identified VRE organism at that time. In addition, she revealed the facility failed to protect the staff and other residents from the potential of infection from 02/18/12 until 02/29/12 by not placing the resident in Contact Isolation when the results of the urine culture first reported VRE. Further interview revealed there was not a process in place to ensure, as the Infection Control Nurse, she had reviewed all the laboratory results and taken action or follow-up as needed. 2. Further review of the facility's Infection Control Manual for Long Term Care: Contact Precautions under the section labeled "Resident Placement", revealed a decision would be made on a case-by-case basis regarding the safety of placing the resident on contact precautions in a room with another resident.	F 441	5. 3/30/12 D. Laundry Services— Linens are handled in a manner which prevents the cross-transmission of infections. This facility was built in 1968 and has limited laundry space. There have not been any infections transmitted due to their laundry practices. A privacy screen has been placed in the center of the room to designate clean and dirty. Upon entering the room, the right hand side of the room is considered dirty and the left is considered clean. Regarding washing machine temperatures, immediately there was no laundry services performed until washing machine temperatures were checked by the maintenance director and in compliance with Shur-guard manufacturer's guidelines. An "on the spot" inservice with staff that were currently working, which was conducted by the maintenance director, and a temperature log was put in place; as well as to notify the Administrator or maintenance	3/30/12

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F 441	Continued From page 135 Further review of the Fact Sheet Vancomycin-Resistant Enterococcus (VRE), dated 2012, revealed under the section Room Considerations; revealed the infection control practitioner, other designee, or management team should determine whether a semi-private room with a low-risk roommate is acceptable. Record review for Resident #5, revealed the facility admitted the resident on 08/06/07 with diagnoses which included Diabetes Type II and Chronic Obstructive Pulmonary Disease. Interview, on 03/15/12 at 5:15 PM, with the DON/ICN revealed Resident #5 was in room D 35 which was shared with Resident #8 who had VRE in his/her urine. When asked about roommate placement the DON stated they did not have isolation rooms available. When asked if Resident #5 would be considered immunocompromised, she stated she would consider someone with Diabetes to be considered immunocompromised. Observation, on 03/16/12 at 7:05 PM, revealed four (4) staff assisting with Resident #8, cleaning up stool and helping to transfer the resident to bed. Disinfectant Virex was used on the resident's wheelchair and floor after the stool was removed. All staff had on gowns and gloves. The PTA was observed to leave room without washing hands after removing PPE. All other staff who had assisted with care washed their hands in the residents shared bathroom after removing their PPE. Interview with the PTA, on 03/21/12 at 10:30 AM, revealed Resident #8's colostomy bag had opened and stool went all over. He stated he	F 441	director immediately if temperatures were below 95 degrees Fainheit and to halt laundry services if this were to occur. 1. No residents have been affected by the handling of linens. 2. All residents are observed for signs and symptoms of infection on an ongoing basis utilizing Interact II tools. The early warning tool will be utilized by all staff to identify any resident with signs and symptoms of infection. 3. An inservice with all housekeeping and laundry staff was conducted on March 16, 2012 at 2:30pm by the Administrator and maintenance director providing instruction to obtain laundry temperatures at least once per shift to ensure the temperature is above 95 degrees Fahrenheit (for Shur-guard to work properly) and maintaining a log of the temperatures. A privacy screen has been put in place to ensure separation of clean and dirty. 4. As part of the facility's on-going quality assurance program the	

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F 441	Continued From page 136 assisted other staff in transferring the resident to his bed. The other staff in the room cleaned up the area. The PTA further stated, after removing his PPE he left the room without washing his hands and went to the men's room, in the hall, to wash his hands. Interview with CNA #1, on 03/20/12 at 10:05 AM, revealed when taking care of Resident #8 the process was to empty his colostomy bag into a bedpan and then empty it into the toilet and then rinse the bedpan using the sink. She stated they did not disinfect the area. She further stated she would wash her hands in the shared bathroom after removing PPE. She stated Resident #5, the roommate of Resident #8, would use the toilet in the bathroom. She felt it was an infection control risk for Resident #5. Interview with LPN # 3, on 03/20/12 at 3:15 PM, revealed after taking care of Resident #8 she would remove her PPE and wash her hands in the shared bathroom, prior to leaving the room. She stated the resident's roommate (Resident #5) did use the toilet in the bathroom by himself/herself and this would be an infection control issue for the resident. Continued interview with the DON/ICN, on 03/15/12 at 5:15 PM, regarding the potential to contaminate surfaces (with VRE/MRSA) by staff leaving the room of a resident on contact precautions to wash hands in the mens/women's bathroom revealed staff could use the hand sanitizer they carried in their pockets before going into the bathrooms in the hall. She admitted she had not instructed staff about using the hand sanitizer before leaving the rooms and did not do	F 441	housekeeping supervisor will audit the laundry room for proper separation and washer temperature logs daily (Monday through Friday) for the next 90 days and then at least weekly. On the weekends the charge nurse will conduct these audits. Any issues identified will be reviewed with the Administrator and Medical Director. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, Dietary Supervisor, Housekeeping Supervisor, Maintenance Supervisor, Activity Director and Social Services, will in turn develop an action plan for any identified issue noted above. 5. 3/30/12	3/30/12

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F 441	Continued From page 137 any audits of staff hand hygiene practices. However, she further stated it was important for staff to use correct hand hygiene with residents in contact isolation. Further interview revealed Resident #6 (VRE in urine) had a urinary catheter which collects his/her urine in a bag. She further stated staff emptied the urine from the bag into a urinal and then poured the urine into the commode of his/her bathroom (which connects with room D 17 shared by Resident #13 and Resident #15). Further interview revealed staff then rinsed the urinal in the sink and poured the contents into the commode. She stated Resident #8 (VRE in urine) had a colostomy bag (which collected his/her stool) and staff would empty the contents into a bedpan and then empty this into the commode of the bathroom being shared by his roommate (Resident #5). When asked about disinfecting to prevent the other residents who use the bathrooms from being contaminated, the DON/ICN revealed staff knew they can use Virex (a disinfectant that kills VRE and MRSA) after emptying the urine (Resident #6) and feces (Resident #8) into the commodes of their respective shared bathrooms; however, had not been specifically inserviced to do this procedure. Continued interview, revealed when residents were newly identified or new residents admitted with Multi-Drug Resistant Organisms the facility did not re-inservice staff on what specific actions would be required. She stated, the staff had taken care of residents with with Multi-Drug Resistant Organisms before and had a manual to reference. Further interview revealed it would be important to do a refresher inservice when residents were placed in contact isolation. 3. Review of Resident #6's Inpatient Discharge	F 441		

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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	Continued From page 138 Summary from a local Hospital, discharge date, 02/24/12, revealed under Medical Hospital Course, the resident was placed on contact precautions for MRSA positivity, VRE, multidrug resistant Pseudomonas and Enterobacter infections, now resolving. Review of the medical record revealed the resident was admitted by the facility on 02/24/12 with diagnoses which included Cerebral Vascular Accident with Left Sided Weakness, Diabetes Type II, Retention of Urine, Hypothyroidism, and MRSA. Review of the Nurses Notes dated 02/24/12 revealed Resident #6 was placed on contact precautions upon admission. Review of the Comprehensive Care Plan, dated 03/06/12, included a focus for contact precautions due to MRSA in the sputum and having VRE in the urine. Review of Resident #6's Admission Physician's Orders, dated 02/24/12, revealed no antibiotics were ordered. Interview with the DON/ICN, on 03/15/12 at 5:15 PM, revealed Resident #6 was admitted with MRSA in his sputum and VRE in his urine and was on contact precautions. She stated, in order to take a resident off contact precautions, they need three negative cultures. She further stated, Resident #6 had one negative urine VRE culture screen so far, but they were waiting on more lab cultures. Review of the laboratory data, revealed lab specimens had been collected for sputum and urine on 02/28/12, which revealed MRSA organisms were isolated from the resident's sputum; however, no VRE organisms were	F 441		

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	185307		03/29/2012

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

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F 441	Continued From page 139 isolated from the urine. Review of the MRSA lab result, collected 02/28/12, revealed it was faxed to the resident's physician on 03/02/12 by LPN #4; however, no antibiotics were ordered and there was no documented evidence of follow-up by the facility related to the laboratory result denoting MRSA of the sputum. Further review of the laboratory data revealed lab specimens from the residents sputum and urine were again collected on 03/11/12. The sputum lab culture identified heavy growth of MRSA and the final report, dated 03/14/12, was faxed to the Physician, on 03/14/12, per review of the lab slip. Review of the Physician's Orders, dated 03/16/12, revealed orders for Bactrim DS (antibiotic medication) twice a day for ten (10) days. Further interview with the DON/ICN, on 03/20/12 at 2:55, regarding the MRSA lab result from the lab collected on 02/28/12, revealed the resident was not on an antibiotic to treat the MRSA at that time. She stated, the final lab report, dated 03/01/12, showed MRSA was isolated and the lab was faxed to the Physician on 03/02/12. Further review of the medical record, revealed there was no documented evidence the facility contacted the Physician about the results for treatment orders. Continued interview, revealed if staff did not receive an order for an antibiotic after faxing the result, the facility should have followed up with the Physician. She stated, it was her responsibility as the ICN to see that an antibiotic was ordered; however, she thought the resident was already on an antibiotic. She further stated, she should have checked the medical record when the 03/01/12 lab result was received to	F 441		

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

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F 441	Continued From page 140 ensure Resident #6 was on an antibiotic. 4. Review of the facility's Infection Control Manual for Long Term Care: Contact Precautions, revealed this facility would use Contact Precautions in addition to Standard Precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. Review of the section "Gloves and Hand Hygiene", revealed gloves should be removed and hands should be washed immediately. Review of the section "Gowns", revealed a gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with environmental surfaces, or items in the resident's room. Review of the section "Contact Precautions May Be Considered for (Examples)" included MRSA and VRE. Review of the Fact Sheet Vancomycin-Resistant Enterococcus (VRE), dated 2012, revealed under the section Special Considerations revealed VRE can cause heavy environmental contamination. Emphasis on high-touch surfaces in patient-care areas (e.g. bed rails, carts, doorknobs, or faucet handles) is important in environmental decontamination. Increasing the frequency of environmental cleaning may be helpful. Review of the Centers for Disease Control and Prevention (CDC) guidelines; 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, revealed the cleaning and disinfection of all patient care areas is important for frequently touched surfaces, especially those closest to the patient, that are most likely to be contaminated ie,	F 441		

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F 441	Continued From page 141 bed rails, bedside tables, commodes, doorknobs, sinks, surfaces and equipment in close proximity to the patient. Further review revealed the frequency or intensity of cleaning may need to change based on the patient's level of hygiene and the degree of environmental contamination and for certain for infectious agents. Interview with DON/ICN, on 03/15/12 at 5:15 PM, revealed the facility's infection control procedures included contact precautions. She stated their process for removing contact isolation was to obtain three negative cultures from the site of the infection before the the contact isolation was removed. She stated, Resident #6 was admitted to the facility with MRSA in his/her sputum and VRE in his/her urine. She further stated, Resident #8 had VRE in his/her urine. Continued interview, revealed both residents were on contact isolation. She stated staff was to wear gloves and gowns when caring for both residents and because Resident #6 had MRSA in his/her sputum, staff was to wear masks when in the room. She further stated, staff was to wash their hands after they exited both resident rooms. She stated they went into the woman's bathroom in the hallway to wash their hands after exiting the rooms. Observation on, 03/13/12 at 4:50 PM, of Resident #6's room revealed a Contact Isolation sign on the door, a stop sign across the door, and Personal Protective Equipment (PPE): gowns, gloves, masks on a hanging shelf on the door. In the room was a biohazard bag set up near the door. Observation, on 03/15/12 at 1:20 PM, revealed	F 441		

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F 441	Continued From page 142 Physical Therapy Assistant (PTA) #1 was in a gown sitting on the bed of Resident #6 providing care. PTA #1 was observed to get up off the bed to leave the room and observation of his back revealed the gown did not completely cover his clothes including the area that was seated on the resident's bed. PTA #1 removed his gown, gloves, mask and then exited the room without washing his hands. He was observed going into the Men's room in the hall. Interview with PTA #1, on 03/15/12 at 1:35 PM, revealed he sat on Resident#6's bed because he was working with the resident on his/her posture. When informed it was observed the gown did not cover his back area, he stated it must have opened up when he sat on the bed. He stated he may need to put on another gown to cover the back to prevent spreading the organism. Further interview revealed he washed his hands after he left the contact isolation room, even though there was a sink in Resident #6's room. He stated he normally went to the nearest bathroom which was the men's bathroom in the hall to wash his hands after leaving the contact isolation room instead of washing his hands prior to leaving the room. Continued interview with DON/ICN regarding the observation of the PTA #1 sitting on the bed of Resident #6, on 03/15/12 at 5:15 PM, revealed staff should not sit on the bed of Resident #6 unless they were completely covered because of the risk of contaminating their clothes and spreading the organism (MRSA). Interview with LPN #6, on 03/15/12 at 5:00 PM, revealed before entering Resident 6's room she put on her gown, gloves, and mask. She stated,	F 441		