

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

PRINTED: 10/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/22/2011
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 000	INITIAL COMMENTS	F 000	Hilltop Lodge does not believe nor does the facility admit that any deficiencies exist.	
F 203 SS=D	<p>An Abbreviated Survey investigating ARO#KY00017104 was initiated on 09/22/11 and concluded on 09/22/11. ARO#KY00017104 was substantiated with deficiencies cited at 42 CFR 483.12 (F203) at a scope/severity of a "D".</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice spscified in paragraph (a)(4) of</p>	F 203	<p>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.</p>	

RECEIVED  
OCT 12 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kathleen Kravica* TITLE: Executive Director (X6) DATE: 10/11/11

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.

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

PRINTED: 10/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED.  <b>C</b> <b>09/22/2011</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40380</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203	<p>Continued From page 1</p> <p>this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's standardized discharge notice it was determined the facility failed to ensure the discharge notice provided the required information for one (1) of three (3) sampled residents, (Resident #1). Resident #1 was discharged from the facility and the facility failed to provide a discharge notice with adequate and correct information during the discharge process.</p> <p>The findings include:</p> <p>Record review revealed Resident #1 was discharged from facility to another facility and was given incorrect information on the discharge</p>	F 203	<p>Hilltop Lodge offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents.</p> <p>Hilltop Lodge strives to provide the highest quality care while assuring the rights and safety of all residents.</p> <p>F203 It is and was on the day of survey the policy of Hilltop Lodge to accurately complete notice requirements before transfer or discharge.</p> <ol style="list-style-type: none"> <li>1. Resident #1 was discharged to another facility prior to this survey. The resident has adjusted well to his new environment.</li> <li>2. All other residents have been reviewed by the Director of Nursing on 9/23/11, and no other residents were affected by this practice. Any residents being transferred or discharged will be notified, or their legal representative will be notified, of the transfer or discharge. This notice will include the reasons for the move in writing and in a language and manner they can understand.</li> </ol>	10/11/11

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

PRINTED: 10/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/22/2011
NAME OF PROVIDER OR SUPPLIER  HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 559 OWINGSVILLE, KY 40360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 203	<p>Continued From page 2</p> <p>paperwork. Review of the discharge notice revealed the contact information including the telephone number was incorrect under the category "Appeal Rights". The information read, Division of Human Resources, Division of Licensing and Regulations (502)564-2800, 275 Main Street, #4E, Frankfort, KY 40621. Additional review revealed the information to contact the local Long-Term Care Ombudsman at 606-849-9651, Ombudsman #1, which was the incorrect name for the Ombudsman. Further review of Resident #1's discharge notice revealed Resident #1 did not sign the transfer/discharge form and the date of notification of responsible party was blank.</p> <p>Record review of Resident #2 and Resident #3 revealed there was no evidence of a transfer and discharge form in their closed charts.</p> <p>Interview with the Administrator, on 09/22/11 at 3:35 PM, revealed the discharge paperwork for Resident #1 appeared completed. Further interview revealed, there was no handwritten explanation of discharge, no date when the responsible party was notified, incorrect name, incorrect address, incorrect telephone number for the appeal rights and there was no signature of Resident #1 on the form.</p> <p>Interview with the Social Services/Admissions Director, on 09/22/11 at 4:30 PM, revealed it was the responsibility of the nursing staff to complete the transfer and discharge form prior to allowing residents to be discharged. Further interview revealed the information on the form was incorrect and should have been corrected when the information had changed. The Social</p>	F 203	<p>3. All nurses (LPN and RNs) were inserviced on 9/30/11 by the Director of Nursing that all information, including reason for the move, must be included in writing on the transfer/discharge form and the resident or legal representative must be notified. All transfer/discharge forms have been manually corrected by the Office Manager on 10/10/11 to include correct telephone numbers and addresses, as well as accurate names of offices and individuals to ensure compliance with the resident's right of appeal, ombudsman and appropriate protection and advocacy agency for residents will mental illness or mental retardation.</p> <p>4. As part of the facility's ongoing Quality Assurance program the Director of Nursing will complete a monthly review of 10% of all resident transfer/discharges for six months to ensure accuracy of notification and documentation; all findings will be reported to the Executive Director.</p>		

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

PRINTED: 10/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/22/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILLTOP LODGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>521 EAST HIGH STREET, P O BOX 559</b> <b>OWINGSVILLE, KY 40380</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 203	<p>Continued From page 3</p> <p>Services/Admissions Director stated the form had been explained to the resident by her/himself prior to discharge.</p> <p>Interview with the Director of Nursing (DON), on 09/22/11 at 4:45 PM, revealed the nurse completing the discharge was responsible for completing the transfer/discharge form. Further interview revealed the DON did not or could not explain why the nurse did not complete the form.</p> <p>Interview with the Administrator, on 09/22/11 at 5:00 PM, revealed Administration was not aware the information on the transfer/discharge form was incorrect and would be corrected.</p>	F 203			