

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

PRINTED: 04/22/2010
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 04/08/2010
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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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(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		
F 221 SS=D	<p>A Recertification Survey was conducted 04/06/10 through 04/08/10 and a Life Safety Code Survey was conducted on 04/07/10. Deficiencies were cited with the highest scope and severity of a "F".</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of ten (10) sampled residents were free from physical restraints (Resident #6). Resident #6 was utilizing a seat belt while in the wheelchair, however, there was no documented evidence a pre-restraint evaluation was completed and no evidence the responsible party was notified of the risks versus benefits of the seat belt and consent obtained.</p> <p>The findings include:</p> <p>Review of Resident #6's medical record revealed diagnoses which included Cerebral Vascular Accident (CVA) with Right Hemiplegia. Review of the Significant Change Minimum Data Set (MDS) dated 03/10/10 revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making and as requiring extensive to total assistance with Activities of Daily Living.</p>	F 221	<p>Hilltop Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist.</p> <p>Hilltop Nursing and Rehabilitation Facility 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 Nursing and Rehabilitation Facility 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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 5-13-10
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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 221	<p>Continued From page 1</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 03/10/10 revealed the resident had a history of falls, confusion and disorientation. Further review of the RAPS revealed the resident had a self-releasing safety belt to remind him/her not to get up alone and to have staff assist. The RAPS further stated, the resident needed to be assessed for the safety belt to determine if the belt was a restraint and if the resident could release it on demand.</p> <p>Review of the Plan of Care dated 03/10/10 revealed the resident had potential for falls related to an unsteady gait, a history of falls at home, confusion, and weakness secondary to Status Post CVA. The interventions included a self-releasing safety belt while up in the wheelchair.</p> <p>Review of the Physicians's Orders dated 04/10/10 revealed orders for a self-releasing seat belt for leaning, getting up alone, history of falls, and Status Post CVA.</p> <p>Observation of Resident #6 on 04/07/10 at 9:05 AM revealed the resident was in his/her room sitting in a wheelchair with a seat belt around the waist.</p> <p>Further review of the medical record revealed there was no documented evidence of a pre-restraint assessment was completed prior to the use of the self-releasing seat belt. In addition, there was no evidence the risks versus benefits were explained to the responsible party or a consent was obtained from the responsible party for the seat belt.</p> <p>Review of the Resident Incident Accident Form</p>	F 221	<p>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 Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Hilltop Nursing and Rehabilitation Facility 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 Nursing and Rehabilitation Facility strives to provide the highest quality care while assuring the rights and safety of all residents.</p>	

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F 221	Continued From page 2 revealed the resident sustained a fall on 01/17/10 at 6:55 PM while attempting to transfer self to bed without assistance Interview on 04/08/10 at 9:15 AM with the Director of Nursing (DON) revealed the resident received the safety belt on 01/17/10 as a new intervention due to the fall occurring that day. Further interview revealed the resident could release the seat belt at times; however, could not always release the seat belt on command. The DON stated a pre-restraint assessment should have been completed for the safety belt and a consent form explaining the risks versus benefits should have been signed by the responsible party. Review of the facility Physical Restraint Policy and Procedure revealed the medical record must indicate the events leading up to the necessity of the restraint and an evaluation would be completed by the interdisciplinary team including therapists to ensure the least restrictive device was used. Further review of the Policy and Procedure revealed restraints would only be used with informed consent of the resident or acknowledgement from the representative.	F 221	<u>F221 483.13(a) Right to be free from physical restraints</u> It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to assure residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. 1. A pre restraint evaluation has been completed and the responsible party notified for resident #6. 2. All residents with restraints have been identified to ensure a pre restraining evaluation and proper notification of responsible party has been completed. 3. An inservice was conducted on April 28, 2010 by the executive director with the director of nursing and all licensed nursing staff regarding proper notification of responsible	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged 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	F 280		

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F 280	<p>Continued From page 3</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility to ensure Plans of Care were reviewed and/or revised to include interventions the facility had identified related to falls for three (3) of ten (10) sampled residents (Resident #6 #7 and #1).</p> <p>The findings include:</p> <p>1. Review of Resident #6's medical record revealed diagnoses which included Cerebral Vascular Accident (CVA) with Right Hemiplegia and a History of Falls. Review of the Significant Change Minimum Data Set (MDS) dated 03/10/10 revealed the facility assessed the resident as having short and long term memory loss, as requiring extensive assistance with transfers and ambulation, and as having sustained a fall in the past 31-180 days.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 03/10/10 revealed the resident needed monitoring for falls and injuries. Further review of the RAPS revealed the resident was encouraged to get up in the wheelchair daily</p>	F 280	<p>party and proper pre restraint evaluation.</p> <p>4. The Executive director and/or her designee will audit three charts a month for six months to assure pre restraining assessments and family notification are carried out according to facility policy.</p> <p>5. Completion date- April 30, 2010.</p> <p><u>F 280 483.20(d)(3), 483.10(k)(2)</u> <u>Right to participate in planning care-revise</u></p> <p>It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to review and/or revise the plan of care..</p> <p>1. The plan of care for residents #6, #7 and #1 have been updated to reflect appropriate interventions related to falls.</p> <p>2. The plan of care for all residents has been reviewed to assure appropriate interventions</p>	

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F 280	<p>Continued From page 1 and ambulate with the assistance of two (2) staff.</p> <p>Review of the Resident Incident/Accident Form revealed the resident sustained a fall on 01/17/10 at 6:55 PM while attempting to transfer self to bed without assistance. Further review of the Form revealed the recommendation/action taken was to ensure staff assisted the resident to bed upon taking him/her to the resident's room.</p> <p>Review of the Resident Accident Form revealed the resident sustained a fall on 02/22/10 at 10:10 AM while in the shower room. The Form revealed the recommendation/action taken was to have staff assist the resident during showers or use a safety belt.</p> <p>Review of the Plan of Care dated 03/10/10 revealed the resident was at risk for falls. There were several fall interventions listed; however, there was no documented evidence the Plan of Care was revised to include interventions related to ensuring staff assisted the resident to bed upon taking him/her to the resident's room and no interventions related to shower safety.</p> <p>2. Review of Resident #7's medical record revealed diagnoses including Parkinson's Disease and Seizure Disorder. Review of the Admission Minimum Data Set (MDS) dated 03/29/10 revealed the facility assessed the resident as having severe impairment in cognitive skills, as requiring extensive assistance with transfers and ambulation, and as sustaining a fall in the past 30 days.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 03/29/10 revealed the resident had a history of falls, and required the</p>	F 200	<p>have been reflected on the care plan.</p> <p>3. An inservice was conducted on April 28, 2010 by the executive director with the director of nursing and all licensed nursing staff regarding importance of updating care plan to reflect interventions utilized in fall prevention.</p> <p>4. As part of the facility's ongoing quality assurance process, the director of nursing and/or her designee will audit 3 resident care plans a month for 6 months to determine if interventions have been updated on plan of care.</p> <p>5. Completion date- April 30, 2010.</p> <p><u>F281 483.20(k)(3)(i) Services provided meet professional standards</u></p> <p>It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to</p>	

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F 280	<p>Continued From page 5</p> <p>assistance of one to two staff and a walker for ambulation.</p> <p>Review of the Resident Incident/Accident Form revealed the resident sustained a fall on 03/25/10 at 7:20 PM while attempting to transfer self to bed. Further review of the Form revealed the recommendation/action taken would be to assist the resident into the bed after supper.</p> <p>Review of the Plan of Care dated 03/29/10 revealed the resident had the potential for falls related to an unsteady gait, weakness, a history of falls, and Alzheimers Dementia. There were several fall interventions listed; however, there was no evidence the Plan of Care was revised to include the intervention to assist the resident to bed after supper.</p> <p>3. Review of Resident #1's medical record revealed diagnoses which included Dementia, Arthritis, and Contractures of the Legs. Review of the Quarterly Minimum Data Set (MDS) dated 03/19/10 revealed the facility assessed the resident as having both long and short term memory problems, as requiring extensive assistance to transfer, and as being unable to ambulate.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/02/10 revealed the resident required total care from the staff for Activities of Daily Living. Further review of the RAPS revealed the resident was non-weight bearing, non ambulatory and needed to be monitored for falls and injuries.</p> <p>Review of the Resident Incident/Accident Form revealed the resident sustained a fall on 03/26/10</p>	F 280	<p>provide services that meet professional standards of quality.</p> <ol style="list-style-type: none"> 1. The physician orders for resident # 1 have been thoroughly reviewed to assure all orders have been implemented appropriately as ordered by physician. 2. Physician orders for all residents have been reviewed to assure physician orders are accurate and implemented as ordered. 3. An inservice was conducted on April 28, 2010 by the director of nursing with the nursing staff regarding the importance of implementing physician orders, paying specific attention that orders are carried over each month by nurse conducting change over, and proper lab procedure to assure labs are obtained as ordered. 4. As part of the facility's ongoing quality assurance process, the director or nursing and /or her designee will audit 3 	

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F 280	<p>Continued From page 6</p> <p>at 2:15 PM. The Form stated the resident slid out of the bed on to the floor. Further review revealed the recommendation/action taken was to ensure the resident was assisted out of the bed and into the recliner chair early, and to monitor the resident closely.</p> <p>Review of the Plan of Care revealed the resident had impaired physical mobility related to leg contractures with interventions to utilize the wheelchair for long distances and to transfer the resident with a mechanical lift. Further review of the Plan of Care revealed the resident required the top siderails to be up in the bed to mark the perimeter of the bed for safety with interventions for a bed alarm. However, there was no documented evidence the Plan of Care was revised to address this residents risks for falls with interventions to prevent further falls, including assisting the resident out of the bed and into the recliner chair early in the day.</p> <p>Interview on 04/08/10 at 9:15 AM with the Director of Nursing (DON) revealed she was ultimately responsible for revising the Care Plans although any nurse could update them. She further stated, she reviewed all the falls daily, and the Care Plans should have been revised immediately to include the fall interventions noted on the Resident Incident/ Accident Forms for Resident #6, #7 and #1.</p> <p>Review of the facility Care Plan Policy and Procedure 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 can be made. Daily care and documentation must be consistent with the resident's care plan".</p>	F 280	<p>charts a month for six months and compare charts with what is being implemented to assure all physician orders are carried out as ordered.</p> <p>5. Completion date- April 30, 2010.</p> <p><u>F 309 483.25 Provide care/services for highest well being</u></p> <p>It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to provide the necessary care and services to attain or maintain the highest well being for each resident.</p> <ol style="list-style-type: none"> 1. Resident #1 and #6 had no effects as the result of lack of 24 hour follow up assessment and a follow up assessment has been completed. 2. All residents with falls are now assessed each shift for 24 hours following falls according to facility policy. 	

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure Physician's Orders were implemented /followed for one (1) of ten (10) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of Resident #1's medical record revealed diagnoses which included Dementia, Arthritis, Contractures of the Legs, Congestive Heart Failure and Atrial Fibrillation. Review of the Quarterly Minimum Data Set (MDS) dated 03/19/10 revealed the facility assessed the resident as having both long and short term memory problems, as requiring extensive assistance to transfer, as being unable to ambulate, and used oxygen.</p> <p>Review of the Physician's Orders dated 03/29/10 revealed orders for a bed alarm on the bed to alert staff of the resident's attempts to get up unassisted.</p> <p>Observation of Resident #1 on 04/06/10 at 9:25 PM, 04/07/10 at 9:45 AM, and 2:00 PM revealed the resident was lying in the bed. There was no evidence of a bed alarm on the bed.</p> <p>Interview on 04/07/10 at 4:00 PM with Certified Nursing Assistant (CNA)#1, revealed she was</p>	F 281	<ol style="list-style-type: none"> 3. An inservice was conducted on April 28, 2010 by the director of nursing with the licensed nursing staff regarding falls protocol and proper follow up assessment and documentation after a fall. 4. As part of the facility's ongoing quality assurance process, the Director of Nursing and/or her designee will audit 3 charts a month for 6 months to assure assessment and documentation has been completed according to facility policy. 5. Completion date- April 30, 2010. <p><u>F323 483.25(h) Free of accident</u></p> <p>It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to provide a resident</p>	

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F 281	<p>Continued From page 8</p> <p>not assigned to Resident #1, however she was often assigned to the resident and was aware the resident was to have a bed alarm. She checked Resident #1's bed and stated there was no bed alarm on the bed.</p> <p>Interview on 04/07/10 at 4:25 PM with Licensed Practical Nurse (LPN)# 1 who was assigned to the resident, revealed she was aware the resident was to have a bed alarm on the bed. She further stated the Nurse Aides were to follow the Nurse Aide Care Plan. Record review revealed the bed alarm usage was noted on the Nurse Aide Care Plan.</p> <p>Interview on 04/08/10 at 1:00 PM with CNA #2 who was assigned to Resident #1 on 04/07/10, revealed she checked the Nurse Aide Care Plans once a week for guidelines on delivery of care. She further stated, she carried an Assignment Sheet in her pocket as a guideline for delivery of care. Continued interview, revealed the CNA's were to check to ensure safety devices were in place at the beginning of each shift; however, she was unaware the resident was to have a bed alarm. Record review of the Assignment Sheet at that time, revealed the bed alarm was not noted on the Assignment Sheet for Resident #1.</p> <p>Interview on 04/08/10 at 10:00 AM with the Director of Nursing, revealed the bed alarm was placed on the Plan of Care on 03/26/10 after the resident sustained a fall and a Physician's Order was obtained for the alarm on 03/29/10. She stated she was unsure why the bed alarm was not on the bed as per the Physician's Orders.</p> <p>Also, further review of the Physician's Orders for Resident #1 revealed orders dated 03/27/10 to</p>	F 281	<p>environment as free as possible of hazards.</p> <ol style="list-style-type: none"> 1. Resident #1 now has alarm in place as intervention for fall prevention. All potentially hazardous items have been removed and are out of reach of residents. 2. All residents have been reviewed to assure alarms and/or other safety devices are in place as ordered. All areas of facility have been assessed for potentially hazardous items and items have been removed as appropriate. 3. An inservice was conducted by the Director of nursing with the nursing assistants, licensed nursing staff and certified medication aides regarding importance of making sure alarms and 		

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F 281	<p>Continued From page 9</p> <p>apply Polysporin Powder to the wound on the lower left leg and cover with a dry dressing every day. Review of the April 2010 monthly Physician's Order Form revealed there were no Orders for a dressing change to the lower left leg.</p> <p>Review of the Treatment Administratio Record (TAR) revealed there was no intervention related to a dressing change for the resident's wound on the left lower leg.</p> <p>Observation of a skin assessment and dressing change for Resident #1 on 04/07/10 time revealed Licensed Practical Nurse (LPN) #2 removed the soiled dressing which was dated 04/05/10 and cleansed the wound on the resident's left lower leg with Wound Cleanser. She then patted the area dry with a gauze pad and covered the wound with Cosmospore Absorbent Adhesive Dressing.</p> <p>Interview on 04/08/10 at 10:00 AM with LPN #2 revealed she was unaware the resident had a wound to the left lower leg until she did the skin assessment and discovered the old dressing. She stated, she then just cleaned the area with Wound Cleanser and placed a dry dressing because there was no order on the TAR for a dressing change. Further interview, revealed she should have called the Physioian and notified him of the wound on the left lower leg and the need for a treatment order.</p> <p>Interview on 04/08/10 at 10:00 AM with the DON, revealed the Polysporin Powder was ordered for the wound on 03/27/10 and the Physician's Order should have been transcribed to the April 2010 TAR and the April 2010 Physician's Order Form. Further interview, revealed she had noted a</p>	F 281	<p>other safety devices are in place as ordered and any potentially hazardous items are locked up away from resident's reach.</p> <p>4. The Director of Nursing and/or her designee will randomly audit three residents every month for 6 months to assure alarms and/or safety devices are in place as ordered. She will also randomly tour the facility three times a month for six months to assure all potentially hazardous items are out of reach of residents.</p> <p>5. Completion date- April 30, 2010.</p> <p><u>F332 483.25(m)(1) Free of medication error rates of 5% or more</u></p> <p>It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to</p>	

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

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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 04/08/2010
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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 281	<p>Continued From page 10</p> <p>problem with the monthly "change over" and Physician's Orders from the prior month were not getting carried over to the current month. Continued interview, revealed one LPN was assigned to do the monthly "change over" for the new Physician's Orders. She stated, once pharmacy sent the new Physician's Orders, the LPN was to check the new months Physician's Orders against the previous months Orders to ensure all current Orders were transcribed to the new MARS, TARS, and Physician's Order Form. She stated she was unaware the resident was not receiving dressing changes to the leg wound as per the Physician's Orders.</p> <p>Continued review of the Physician's Orders for Resident #1 revealed Orders dated 04/04/10 for oxygen at four liters per nasal cannula, check oxygen saturation level every hour to keep oxygen levels above 90 % (percent), if oxygen levels stays below 80% may send to emergency room, notify Physician of condition on Monday 04/05/10.</p> <p>Observation of Resident #1 on 04/06/10 at 9:15 PM, 04/07/10 at 7:25 AM, 8:10 AM, 9:45 AM, 11:30 AM, 12:10 PM, 2:00 PM and 4:00 PM, revealed the resident was not using oxygen.</p> <p>Record Review of the Flow Sheet revealed the last oxygen saturation was obtained on 04/06/10 at 4:00 AM.</p> <p>Review of the Nurse's Notes dated 04/05/10 at 8:15 AM revealed the resident's oxygen saturation was 90% (percent) with oxygen at four (4) liters per nasal cannula. The Note further stated the resident was refusing to keep the oxygen on and at times pulled the oxygen off, was</p>	F 281	<p>ensure that it is free of medication error rates of five percent or greater.</p> <ol style="list-style-type: none"> 1. The medication for unsampled resident, resident #2, and resident # 7 have been reviewed and are now being given correctly per the physician order. 2. All residents' medications have been reviewed to assure all medications are being given correctly per the physician order. 3. An inservice was conducted on April 28, 2010 by the director of nursing with the licensed nursing staff and certified medication aides regarding proper medication administration and their role in making sure the medications are transcribed to the MAR correctly as ordered by the physician. 4. As part of the facility's ongoing quality assurance process, the director of 	

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F 281	<p>Continued From page 11</p> <p>combative with staff, there were no signs and symptoms of an adverse reaction to the antibiotic, and the nurse was unable to reach the Physician due to the Physician was not in the office.</p> <p>Interview on 04/07/10 at 4:25 PM and on 04/08/10 at 10:00 AM with the DON, revealed the Physician's Order for the oxygen and oxygen saturation was for the period when the resident was experiencing an acute illness and the resident no longer required the oxygen or the oxygen saturation levels. Further interview, revealed the nurses should have called the Physician to notify him of the resident's condition on 04/05/10 as ordered, and should have clarified if the Physician wanted continued oxygen and oxygen saturation levels every hour.</p> <p>Review of the Physician's Orders dated 01/05/10 revealed orders to obtain a Prothrombin Time (PT) and an international Normalization Ratio (INR) in two weeks and no changes in Coumadin (anticoagulant medication) dosage at this time.</p> <p>Review of the medical record revealed there was no documented evidence of a PT/INR obtained two weeks from 01/05/10. The laboratory tests drawn 02/01/09 for the PT was 48.0 high and INR was 3.8 high. The laboratory tests for the PT and INR was drawn fourteen (14) days late.</p> <p>Interview on 04/08/10 at 3:00 PM with the Director of Nursing (DON) revealed the nurse who received the order for a laboratory test was to transcribe the lab order to the lab book, fill out a lab requisition slip, and place the slip in a box under the date in which the lab was to be drawn. She stated, if the lab was not due to be drawn that week, the nurse would transcribe the</p>	F 281	<p>nursing and/or her designee will perform 3 medication pass audits a month for 6 months to assure medications are being administered as ordered by the physician.</p> <p>5. Completion date- April 30, 2010.</p> <p><u>F 441 483.65 Infection control, prevent spread, linens</u></p> <p>It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to establish and maintain a sanitary and comfortable environment to help prevent the development and transmission of diseased and infection.</p> <p>1. Resident #1 did not experience a negative outcome from lack of handwashing during the resident's treatment.</p> <p>2. All nursing staff are now using proper handwashing techniques when performing care to the residents.</p>	

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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 281	Continued From page 12 laboratory test order to the lab book and the weekend Registered Nurse (RN) would make out the laboratory requisition slips for the week according to the laboratory book. Continued interview, revealed the nurse who signed the order off on 01/05/10 for the PT and INR to be drawn in two weeks, failed to transcribe the laboratory test to the lab book, and the laboratory test was not drawn. Further interview revealed the night shift nurses compared the laboratory book, with the laboratory slips in the box nightly as a second check. However, the night shift nurses did not compare the Physician's Orders from the medical record with the laboratory requisition slips nightly and if the lab had not been transcribed to the laboratory book, it may be missed.	F 281	3. All licensed nursing staff and certified nursing assistants and certified medication aides were inserviced on April 28, 2010 by the director of nursing regarding proper handwashing techniques before and after performing care on residents. 4. The director of nursing and/or her designee will audit 3 nurses a month performing care to residents for 6 months to assure nursing staff are washing hands as accepted by professional practice. 5. Completion date- April 30, 2010.	
F 309 SS-D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 interview and record review, it was determined the facility failed to provide the necessary care and services for two (2) of ten (10) sampled residents (Resident#1 and #6). The facility failed to ensure residents who experienced a fall were assessed, per facility policy. The finding include:	F 309	<u>F 502 483.75(j)(1)</u> <u>Provide/obtain laboratory services quality/timely</u> It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to provide or obtain laboratory services to meet the needs of its residents.	

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F 309	<p>Continued From page 13</p> <p>Review of the facility Falls Follow up Protocol revealed each resident who experienced a fall would be assessed for complications from the fall including vital signs every shift for the following twenty-four (24) hours. The Protocol further stated, assessment findings including vital signs were to be documented in the medical record.</p> <p>1. Review of Resident #6's medical record revealed diagnoses of a History of Falls and Cerebral Vascular Accident (CVA).</p> <p>Review of Resident #8's Nurses Notes dated 02/22/10 at 10:10 AM revealed the Nurse was called to the shower per the Certified Nursing Assistant (CNA). According to the Note, a large oval abrasion over the right eye the size of a fifty cent piece was noted.</p> <p>Review of the Resident Incident/Accident Report Form for the fall sustained on 02/22/10, revealed Initial vitals signs: Temperature: 98.2, Pulse: 78, Respirations: 20, Blood Pressure: 118/60.</p> <p>Review of the next entry in the Nurse's Notes dated 02/23/10 at 5:00 AM, revealed the resident rested well through the night, was easily awakened, and the dressing to the right brow was clean, dry, and intact. The next entry in the Nurses Notes was dated 03/03/10 at 10:00 AM and was unrelated to the fall.</p> <p>There was no documented evidence of vital signs after the Initial assessment on 02/22/10 at 10:10 AM and no evidence of a nursing assessment after the 02/23/10 assessment at 5:00 AM.</p>	F 309	<ol style="list-style-type: none"> The lab for resident # 1 has now been drawn and reviewed. The labs for all residents have been reviewed to assure all labs have been completed as ordered by the physician. An inservice was conducted with licensed nursing staff on April 28, 2010 regarding laboratory procedures and importance of assuring labs have been completed as ordered. As part of the facility's ongoing CQI process, the director of nursing and/or her designee will audit 3 resident charts per month to review physician orders for labs for 5 months to assure all laboratory orders have been completed. In addition, the director of nursing and/or her designee will monitor the 	

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F 309	<p>Continued From page 14</p> <p>2. Review of Resident #1's medical record revealed diagnoses which included Dementia.</p> <p>Review of Resident #1's Nurse's Notes dated 03/26/10 at 2:15 PM revealed the Nurse was called to the resident's room by the instructor and student. The resident was found sitting on the floor and apparently had slid out of the bed. The resident was lifted to the bed by staff, denied any pain, no injuries were detected, and the resident's Daughter and Physician were notified.</p> <p>Review of the Resident Incident/Accident Report Form for the fall sustained on 03/26/10 revealed the resident's vital signs were; Temperature 100 (high), Pulse 130 (high), Respirations 32 (high), and Blood Pressure 120/88.</p> <p>The next entry in the Nurse's Notes was dated 04/03/10 at 11:25 PM was unrelated to the fall. Although the resident was assessed immediately after the fall on 03/26/10, there was no documented evidence of further assessment of this resident, even though the resident's vital signs were not within normal limits.</p> <p>Interview on 04/08/10 at 9:15 AM with the Director of Nursing (DON) revealed the nurses should follow up with an assessment including vital signs every shift which would be at least every twelve hours after a resident sustained a fall. She further stated, the assessment and vital signs would need to be more often depending on the resident's illness or injury. Further interview revealed the assessment should be documented. The DON was unaware the nurses were not following the Falls Protocol related to assessment and documentation after a fall.</p>	F 309	<p>laboratory book weekly to assure all labs have been obtained as ordered.</p> <p>5. Completion date- April 30, 2010.</p>		
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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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
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F 323 88=E	<p>Continued From page 15</p> <p>HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents received assistance devices to prevent accidents for one (1) of three (3) sampled residents (Resident #1). Also, the facility failed to provide a safe environment related to items left unattended which could pose a danger to the residents.</p> <p>The findings include:</p> <p>Review of Resident #1's medical record revealed diagnoses which included Dementia, Arthritis, and Contractures of the Legs. Review of the Quarterly Minimum Data Set (MDS) dated 03/19/10 revealed the facility assessed the resident as having both long and short term memory problems, as requiring extensive assistance to transfer, and as being unable to ambulate.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/02/10 revealed the resident revealed the resident was non-weight bearing, non ambulatory, and needed to be monitored for falls.</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>Review of the Resident Incident/Accident Form revealed the resident sustained a fall on 03/26/10 at 2:15 PM. The Form stated, the causative factor was the resident sliding out of the bed and on to the floor.</p> <p>Review of the Plan of Care revealed a problem stating the resident required the top siderails to be up in the bed to mark the perimeter of the bed for safety. The interventions included utilizing a bed alarm.</p> <p>Observation of Resident #1 on 04/06/10 at 9:25 PM, 04/07/10 at 9:45 AM, and 2:00 PM revealed the resident was lying in the bed. There was no evidence of a bed alarm on the bed.</p> <p>Interview on 04/07/10 at 4:00 PM with Certified Nursing Assistant (CNA)#1, revealed she was not assigned to Resident #1. She checked Resident #1's bed and stated there was no bed alarm on the bed. She further stated she was often assigned to the resident and a bed alarm should have been on the bed.</p> <p>Interview on 04/07/10 at 4:25 PM with Licensed Practical Nurse (LPN)# 1 who was assigned to the resident, revealed the resident should have had a bed alarm on the bed. She further stated the bed alarm was on the Nurse Aide Care Plan and the aides were to follow the Nurse Aide Care Plan. Record review revealed the bed alarm was on the Nurse Aide Care Plan.</p> <p>Interview on 04/08/10 at 1:00 PM with CNA #2 who was assigned to Resident #1 on 04/07/10, revealed she checked the Nurse Aide Care Plans once a week for guidelines on delivery of care.</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>She further stated, she carried an Assignment Sheet in her pocket as a guideline for delivery of care. Continued interview, revealed the CNA's were to check to ensure safety devices were in place at the beginning of each shift. She further stated, she was unaware the resident was to have a bed alarm. Review of the Assignment Sheet at that time, revealed the bed alarm was not on the Assignment Sheet for Resident #1.</p> <p>Interview on 04/08/10 at 10:00 AM with the Director of Nursing, revealed the bed alarm was placed on the Plan of Care on 03/26/10 after the resident sustained a fall. She further stated, the aides were to review the Nurse Aide Care Plans and sign off to denote they had delivered the care per the Nurse Aide Care Plan. Continued interview, revealed the bed alarm should also have been on the Assignment Sheet which the aides carried in their pockets. She was unaware the intervention for the bed alarm was not on the Assignment Sheet. Further interview, revealed the intervention for the bed alarm was on the Treatment Administration Record (TAR) and the nurses needed to ensure the device was in place prior to signing off the intervention. Record review of the TAR revealed the intervention for the bed alarm had been signed off by the nurse denoting the device was in place on 04/08/10 and 04/07/10. She further stated there was no audit to ensure safety devices were in place except for the monthly audit by Continuous Quality Improvement.</p> <p>Observation on 04/08/10 at 7:00 PM revealed the general bath on the short hall had two (2) cans of shave cream stored on the top of the toilet. The label on the shave cream stated, keep out of the</p>	F 323		

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F 323	Continued From page 18 reach of children. Further observations in the general bath on the short hall revealed an unlocked cabinet containing two (2) Fleets enemas with a label that stated, call poison control if swallowed. Observation on 04/08/10 at 7:10 PM revealed the general bath on the long hall had an unlocked cabinet containing a gallon container of Skin Caring Shampoo and Body Wash which was one half (1/2) full. The label stated call poison control if swallowed and keep out of reach of children. The cabinet also contained Secret Deodorant Spray with a label that stated, inhaling the product could be fatal.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to be free of medication error rates of five percent or greater. Medication pass observations conducted on the morning and afternoon of 04/07/10	F 332		

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F 332	<p>Continued From page 19</p> <p>resulted in the assessment of three (3) medication errors out of forty-one (40) opportunities, for a medication error rate of 7.3 percent.</p> <p>The findings include:</p> <p>1. During the morning medication pass on 04/07/10 at 7:25 AM, an unsampled resident was observed to receive nine oral medications which included a tablet of Aspirin 81 mg. (milligram). Following the medication pass observation, review of the resident's clinical record revealed, on 03/30/10, the Physician had ordered the resident's dose of Aspirin to be increased to "325 mg.". Review of the resident's MAR (Medication Administration Record) revealed the order for the Aspirin had been transcribed as "Aspirin 325 mg." and had been scheduled to be given once daily at 8 AM. Following the discovery of the error, an interview was conducted with LPN #1 (the medication nurse) at approximately 8:30 AM. After reviewing the resident's MAR, she acknowledged the resident should have received Aspirin 325 mg. However, upon checking the resident's medication drawer, she determined that only Aspirin 81 mg. was available for use by the resident. Later that morning, she explained she proceeded to report the situation to the Physician's office and was instructed to continue administering the 81 mg. strength until the supply ran-out and to then switch the resident to the 325 mg. strength. One medication error was assessed as a result of the observation.</p> <p>2. During the morning medication pass at 7:50 AM, Resident #7 was observed to receive fifteen oral medications which included a dose of Synthroid 0.075 mg., a thyroid hormone</p>	F 332			

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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 332	Continued From page 20 supplement. Following the medication pass observation, a review of the resident's clinical record revealed the Synthroid dose was ordered to be administered "every other day". Review of the resident's MAR revealed the resident's previous dose of the Synthroid had been administered the previous day (04/06/10) with the subsequent dose not being due until 04/08/10. During the interview with LPN #1, she acknowledged the dose of Synthroid should not have been given that morning. As a result of the observation, the facility was assessed a second medication error. 3. During the mid-afternoon medication pass on 04/07/10, Resident #2, diagnosed with Macular Degeneration, was observed to receive a dose of I-Cap TR (a vitamin-mineral supplement) at 2:20 PM. Following the medication pass observation, review of the resident's clinical record revealed the resident's medication had been ordered to be given "twice daily with meals to help with macular degeneration". Further review of the resident's record revealed the I-Cap order had been scheduled to be administered each day at "7 AM and 4 PM". However, on the current MAR, staff had changed the schedule time for the afternoon dose from 4 PM to "3 PM", thus scheduling the afternoon dose from approximately 3 hours after the noon meal and approximately 2 hours prior to the evening meal. During an interview with LPN #2 (the medication nurse), she acknowledged the medication should have been given "with meals" according to the Physician's order. As a result of the observation, the facility was assessed with a third medication error.	F 332			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 21</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (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. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (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 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. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	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 880 OWINGSVILLE, KY 40300		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 22</p> <p>Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed diagnoses which included Dementia and a History of Urinary Tract Infections. Review of the Quarterly Minimum Data Set (MDS) dated 03/19/10 revealed the resident was incontinent of bowel and bladder and required total assistance from staff for all Activities of Daily Living.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/02/10 revealed the resident had been in the hospital for a Urinary Tract Infection, was unable to toilet due to mobility status, and was to be monitored for incontinence.</p> <p>Review of the Plan of Care dated 03/19/10 revealed the resident had the potential for infection related to a history of a Urinary Tract Infection. The interventions included; ensure correct perianal cleansing, observe universal precautions, and use good handwashing technique before and after providing care.</p> <p>Observation of peri-anal care on 04/07/10 at 9:45 AM for Resident #1 revealed Licensed Practical Nurse (LPN) #2 used wet wipes to cleanse the stool from the anal area. She then changed gloves and cleansed the peri-area front to back. Using the same gloves, the LPN proceeded to complete an upper body skin assessment,</p>	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 659 OWINGSVILLE, KY 40300		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 441	Continued From page 23 change the resident's gown and pull the resident's blankets up. There was no evidence the LPN washed her hands after cleansing the stool from the anal area and prior to donning new gloves to cleanse the peri-area. In addition, there was no evidence the LPN washed her hands after completing the peri-care and prior to conducting the upper body skin assessment. Interview on 04/07/10 at 9:45 AM with LPN #2 revealed she should have washed her hands after cleansing the stool from the residents anal area. Continued interview, revealed she should have washed her hands after performing peri-care and prior to completing the skin assessment to prevent the transmission of disease.	F 441			
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure laboratory tests were completed as ordered by the Physician for one (1) of ten (10) sampled residents (Resident #1). The findings include: Review of Resident #1's medical record revealed diagnoses including Atrial Fibrillation,	F 502			

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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 502	<p>Continued From page 24</p> <p>Review of the April 2010 Physician's Orders revealed orders for Warfarin Sodium (Coumadin, anticoagulant medication) three milligrams (3 mg) by mouth once daily.</p> <p>Review of the laboratory test results drawn 01/04/10 for the Prothrombin Time (PT) was 36.8 high (reference range 10.5 to 14.1) and International Normalization Ratio (INR) was 3.0 high (reference range 0.9-1.2).</p> <p>Review of the Physician's Orders dated 01/05/10 revealed orders to obtain a Prothrombin Time (PT) and a international Normalization Ratio (INR) in two weeks and no changes in Coumadin dosage at this time.</p> <p>Review of the medical record revealed there was no documented evidence of a PT/INR obtained two weeks from 01/05/10. The laboratory tests drawn 02/01/09 for the PT was 48.0 high and INR was 3.9 high. The laboratory tests for the PT and INR was drawn fourteen (14) days late.</p> <p>Interview on 04/08/10 at 3:00 PM with the Director of Nursing (DON) revealed when the nurse received an order for a lab, the nurse was to transcribe the lab order to the lab book, fill out a lab requisition slip, and place the slip in a box under the date in which the lab was to be drawn. She further stated, if the lab was not due to be drawn that week, the nurse would just need to transcribe the laboratory test order to the lab book and the weekend Registered Nurse (RN) would make out the laboratory requisition slips for the week according to the laboratory book. Continued interview, revealed the nurse who signed the order off on 01/05/10 for the PT and INR to be</p>	F 502			

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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 502	Continued From page 25 drawn in two weeks, failed to transcribe the lab to the lab book, and the laboratory test was not drawn. Further interview revealed the night shift nurses compared the laboratory tests to be ordered from the laboratory book, with the laboratory slips in the box nightly as a second check. However, she further stated, the night shift did not compare the Physician's Orders from the medical record with the laboratory requisition slips nightly. Therefore, if the the laboratory test was not transcribed to the laboratory book the night shift would not catch the mistake.	F 502		
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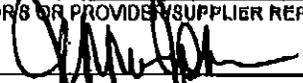
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NAME OF PROVIDER OR SUPPLIER HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 821 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
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K 000	INITIAL COMMENTS	K 000		
K 012 8S=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a construction type with a complete automatic sprinkler system. This condition affected one of two smoke compartments, staff and approximately six (6) residents. The facility has the capacity for 39 beds with a census of 32 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on April 7, 2010 at 9:45 AM, with the Director of Maintenance. Observation at that time revealed an approximate 30 X 10 foot combustible (wood) overhang at the front entrance of the facility. An interview with the Maintenance Director on April 7, 2010 at 9:45 AM revealed the Director of Maintenance was not aware the canopy should be sprinkler protected.</p> <p>Reference: NFPA 13 1999 edition</p>	K 012	<p>Hilltop Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist.</p> <p>Hilltop Nursing and Rehabilitation Facility 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 Nursing and Rehabilitation Facility reserves all rights to raise all possible</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X8) DATE 4/20/10
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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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NAME OF PROVIDER OR SUPPLIER HILLTOP LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 889 OWINGSVILLE, KY 40360	
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K 012	Continued From page 1 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012	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 Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Hilltop Nursing and Rehabilitation Facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents. Hilltop Nursing and Rehabilitation Facility strives to provide the highest quality care	
K 026 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 10.3.7.3, 10.3.7.5, 10.1.6.3, 10.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire/smoke resistance rating of the corridor ceiling area. The deficient practice would affect all smoke compartments, all residents and staff. The facility has the capacity for 39 beds with a census of 32 the day of survey. The findings include: During the Life Safety Code survey on April 7, 2010 at 9:40 AM, with the Director of Maintenance, a wooden pull down set of stairs located in the ceiling of the north corridor was noted not to meet the ½ hour fire rated	K 026		

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NAME OF PROVIDER OR SUPPLIER HILLTOP LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 EAST HIGH STREET, P O BOX 669 OWINGSVILLE, KY 40360
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K 025 Continued From page 2
construction as required for a smoke barrier. The stairs were used to access the attic area for maintenance issues. An interview with the Director of Maintenance on April 7, 2010 at 8:40 AM revealed the Director of Maintenance was not aware the opening in the corridor ceiling was required to maintain a ½ hour fire resistance rating. During the survey the same type of stairs were noted at the nursing station ceiling area.

Reference: NFPA 101 2000 edition

8.3.2* Continuity.
Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.
Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.

K 072 SS=F
NFPA 101 LIFE SAFETY CODE STANDARD
Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

K 025
while assuring the rights and safety of all residents.

K 012 NFPA 101 Life safety code standard

It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to provide a construction type with sprinklers to meet standards.

1. The front entrance of the facility has been assessed and combustible material will be replaced with noncombustible or limited combustible material as soon as parts are available.
2. All exterior roofs and canopies have been assessed to assure the materials are of noncombustible

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NAME OF PROVIDER OR SUPPLIER HILLTOP LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 821 EAST HIGH STREET, P O BOX 889 OWINGSVILLE, KY 40360		
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K 072	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors were maintained free from obstructions to full instant use in the case of fire or other emergencies. The deficient practice would affect all smoke compartments, all residents and staff. The facility has the capacity for 39 beds with a census of 32 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on April 7, 2010 at 9:30 AM, with the Director of Maintenance, a resident scale, resident lift, wheelchair and linen cart were noted not to be in use and unattended in the north wing corridor. An interview with the Director of Maintenance on April 7, 2010 at 9:30 AM revealed these items were routinely left at one side of the corridor because there was not enough storage space in the facility. Corridors are intended for means of egress, internal traffic and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. These items would also limit the use of the handrails by occupants of the building when needed. The east wing corridor was also noted during the survey to contain these types of items.</p>	K 072	<p>material and/or are sprinkler protected.</p> <ol style="list-style-type: none"> 3. An inservice was conducted on April 29, 2010 with the maintenance supervisor by the executive director regarding sprinkler usage and exterior roofs and/or canopies. 4. As part of the facilities ongoing CQI process, the maintenance supervisor and/or his designee will audit any new areas of construction to assure all areas have sprinklers as appropriate or are of noncombustible construction. 5. Completion date- April 30, 2010. 	

K 025 NFPA 101
Life safety code
standard

It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to provide smoke barriers with at least one half hour resistance rating.

1. The corridor ceiling in question will be replaced with material that meets the one half hour resistance rating as required. Parts have been ordered and will be replaced as soon as they become available.
2. All areas have been assessed to assure materials

that meet the one half hour resistance rating are in place.

3. An inservice was conducted on April 29, 2010 with the maintenance supervisor by the executive director regarding proper fire rating of materials.
4. As part of the facility's ongoing CQI process, the maintenance director and/or his designee will audit any new construction to assure all materials used meet the one half hour fire rating as required.
5. Completion date- April 30, 2010.

**K 072 NFPA 101 Life safety
code standard**

It is and was on the day of the survey the policy of Hilltop Nursing and Rehabilitation to ensure corridors are maintained free of obstructions.

1. The scale, lift, wheelchair and linen cart have been removed from corridor.
2. The corridor has been assessed for any items stored in area and items have been removed.
3. An inservice was conducted on April 29, 2010 by the director of nursing with the licensed nursing staff and nursing assistants regarding proper storage of items and blocking of corridor.
4. As part of the facility's ongoing CQI process, the housekeeping supervisor and/or her designee will

**audit the corridor 3 times
a month for 6 months to
assess for corridors free
from obstruction.**

- 5. Completion date- April
30, 2010.**