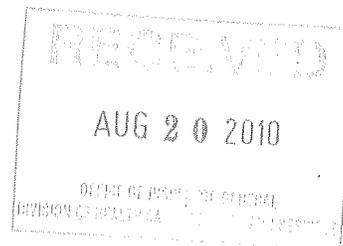


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143	
(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 225	<p>Continued From page 10</p> <p>other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure all potential employees were screened for abuse findings for one (1) of the four (4) sampled employee personnel files and an expanded sample of four (4) additional employee personnel files.</p> <p>The findings include: Record review of four (4) employee personnel</p>	F 225	<p>Director. A retrospective review will be completed for all CNA staff employed for less than three years and additional state registry inquiries will be made as needed and appropriate action taken. Any candidate found to be registered on any abuse registry will not be offered employment. All Nursing Facility nursing and aide staff will be educated on this change by the Facility DON. The HR Director will submit findings from her retrospective reviews for current CNA's and will submit proof of multistate registry inquiries for all new CNA staff for three consecutive months. If 100% compliance is not obtained within three months, the reporting period will extend to six months. Findings will be submitted to the CNO and the Quality Assurance Committee. The Quality Assurance Committee will meet monthly for the duration of the audit period. The Facility DON in conjunction with the HR Director is responsible for maintain compliance with this process change.</p>	



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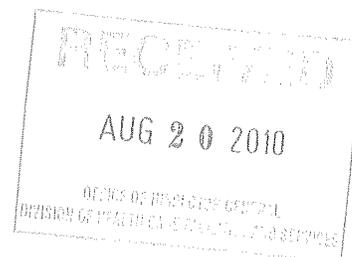
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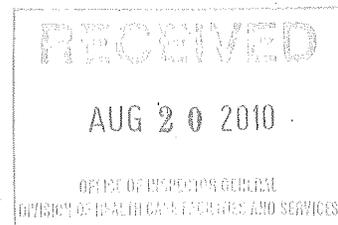
F 225	Continued From page 11 files and an expanded sample of four (4) additional employee personnel files revealed one Dietary Aide hired on 06/30/10 had a work history in the state of Indiana. However, no record was located for a nurse aide abuse registry check in that state. Interview with Human Resources on 07/22/10 at 3:00pm revealed an Indiana nurse aide abuse registry check had not been completed for this employee. However, the facility would complete one on this day. Review of the facility's Abuse policy dated September, 2003 revealed the nurse aide abuse registry would be utilized for verifying status of any nurse assistant and to check all new employees against the abuse registry.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to develop an Abuse policy to address and instruct employees on obtaining nurse aide abuse registry checks for potential employees with a work history in states other than Kentucky. The findings include: Review of eight (8) employee personnel files	F226	The abuse policy will be revised to include protection from mistreatment, neglect and abuse as well as misappropriation of property. All Nursing Facility nursing and aide staff will be educated by the Facility DON regarding this policy revision. The HR director will perform pre-employment abuse screenings on all employees. The HR Director will submit evidence of pre-	8-27-10



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F 226	Continued From page 12 revealed one (1) employee who had a work history in Indiana did not reveal any evidence of a nurse aide abuse registry check in Indiana. Review of the Abuse policy dated September, 2003 revealed the nurse aide abuse registry would be utilized for verification of any nurse assistant's status and to check all new employees against the abuse registry. An employee listed on the abuse registry is not eligible for employment in any area of patient/resident care/contact. However, the policy did not entail how the facility would screen potential employees who had worked in other states. Interview with Human Resources on 07/22/10 at 3:00pm revealed the nurse aide abuse registry check for the one (1) employee had not been completed and the facility would do so on this day. Interview with the Chief Nursing Officer on 07/22/10 at 4:30pm revealed she was not familiar with the requirement for out of state nurse aide abuse registry checks and could only provide the current policy.	F 226	employment abuse screenings to the CNO, Facility DON and Quality Assurance Committee for three consecutive months. If 100% compliance has not been achieved in three months the reporting period will extend to six months. The Quality Assurance Committee will meet monthly for the duration of the reporting period.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F315	MDS Coordinator was educated on 8-9-10 regarding the requirement that all urinary incontinence or other urinary issues must be included in the plan of care and must include interventions aimed to restore the bladder function. Compliance with this requirement will be monitored by the Facility DON or her designee by auditing	8-09-10



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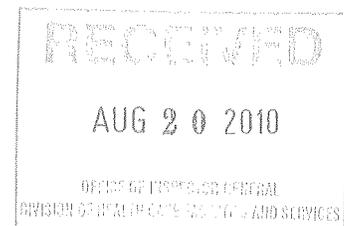
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NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143
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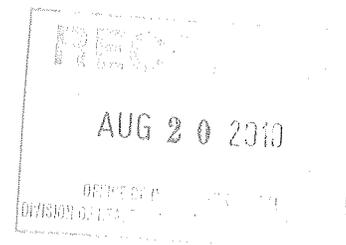
F 315	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide appropriate treatment and services, to prevent urinary tract infections for residents with indwelling catheters, for one (1) of eight (8) sampled residents (#3). Resident #3 had an indwelling catheter which was not protected from contamination.</p> <p>The findings include:</p> <p>The policy and procedure for managing indwelling catheters was requested; however, the policy was not provided by the facility.</p> <p>Observation of Resident #3 on 07/21/10 at 10:15am revealed the resident sitting in a chair with the urinary drainage bag hanging from the chair and touching the floor. Observation at 11:00am, revealed no change in the position of the drainage bag; however, the drainage tubing was noted to be resting on the floor. Observation on 07/21/10 at 12:30pm revealed the drainage bag and the tubing were both on the floor. At 2:00pm, observation revealed the drainage bag was hanging from the chair and the tubing was draped on the floor.</p> <p>Review of the clinical record for Resident #3 revealed the resident was admitted to the facility with a diagnosis of Urinary Retention. The facility completed a quarterly Minimum Data Set (MDS) assessment on 06/23/10 which revealed the resident required total care by staff. The resident had an indwelling catheter and a severe</p>	F 315	<p>the care plans of all patients with foley catheters, urinary incontinence, or other urinary problems for three consecutive months. If 100% compliance has not been achieved the audit period will extend to six months. All audit findings will be reported to the CNO and the Quality Assurance Committee for review. The Quality Assurance Committee will meet monthly for the duration of the audit period. The Facility DON is responsible for compliance with this process change.</p>	
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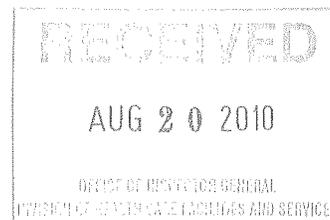
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F 315	Continued From page 14 Impairment in the ability to make daily care decisions. Review of the comprehensive care plan for Resident #3 revealed no evidence of a care plan to address the management of the urinary drainage bag or the tubing connecting the indwelling catheter to the drainage system. Interview with Certified Nurse Aides #4 and #5 on 07/22/10 at 2:00pm, revealed indwelling catheter drainage bags and tubing should not be in contact with the floor due to the floor not being a clean surface and as a result an infection could occur.	F 315		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F356	On 7-29-10 of survey the required and actual staffing available for the facility as well as the discipline of each staff member and the facility census was posted for public viewing at the nurse's station. The posting has continued to be posted and updated each day/shift to reflect actual staffing. Staff education for all nursing and aide staff was conducted by the Facility DON regarding the change in policy and the requirement to update staffing/census with each shift. Policy regarding FTE posting has been created. The Facility DON will observe this posting for accuracy 2 times each week for three consecutive months. If 100% compliance with this process is not	7-29-10



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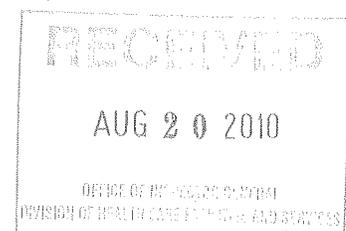
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F 356	<p>Continued From page 15</p> <p>make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined the facility failed to post the total number and actual hours worked by licensed and unlicensed nursing staff directly involved in resident care.</p> <p>The findings include:</p> <p>Observation of the nursing unit on 07/21/10 and 07/22/10 during the standard survey did not reveal the required staffing posted on the unit.</p> <p>Record review of the staffing sheets provided by the facility revealed the staffing sheets were kept in a binder at the nurse's station and not posted for residents and visitors to read. The staffing sheets documented the name of the person on duty for each shift but not the number of hours as required.</p> <p>Interview with the ECF Director on 07/22/10 at 9:00am revealed the staffing sheets were maintained in a binder at the nurse's station. The Director was not aware of the requirement for staffing hours to be documented or that it should be posted for residents and visitors to read.</p> <p>The facility did not produce evidence of a policy</p>	F 356	<p>achieved, the observation period will be extended to six months. Findings of these observations will be reported to the CNO and the Quality Assurance Committee. The Quality Assurance Committee will meet monthly for the duration of the observation period.</p>	



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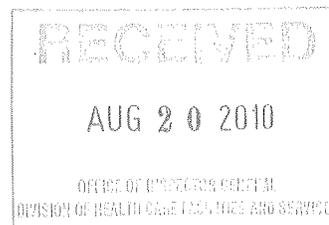
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F 356	Continued From page 16 and procedure for posting of staffing.	F 356		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable 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 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.	F441	On 7-29-10 Nursing Facility nursing and aide staff was educated regarding appropriate procedures for passing ice, meal prep/set up and maintenance of indwelling catheter. A hand out with test regarding Care of a Pt. with a Catheter was given to all CNA's by the Facility DON with a mandatory completion requirement. To ensure compliance with the infection control program the Facility DON in conjunction with the Infection Control nurse will randomly observe 3 patient encounters per week related to these areas for three months. If 100% compliance is not achieved, re-education will be provided to the employee at the time of the incident and the observation period will extend to six months. Observation findings will be reported monthly to the CNO, IC nurse and the Quality Assurance Committee. The Quality Assurance Committee will meet monthly for the duration of the observation period. In addition, a separate Infection Control policy will be	7-29-10



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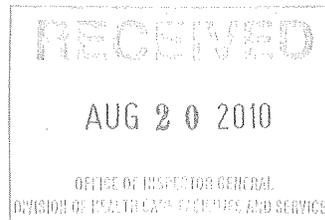
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F 441	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain an infection control program to provide a safe sanitary environment and prevent the spread of disease and infection. Resident #3 was observed to have an indwelling catheter with the tubing and drainage bag coming in contact with the floor. In addition, the ice scoop used during the fluid pass was stored in the ice and staff were observed to touch residents' food during the meal service.</p> <p>The findings include:</p> <p>Observation of Resident #3 on 07/21/10 at 10:15am, 11:00am, 12:30pm, 2:00pm, and 3:00pm, revealed the resident's indwelling catheter tubing and drainage bag was in direct contact with the floor.</p> <p>Observation of CNA #4 on 07/21/10 at 12:00pm revealed he picked up a resident's piece of bread with bare hands to apply butter and opened a package of crackers and removed the crackers with bare hands then gave them to another resident. Observation of CNA #1 on 07/22/10 at 12:20pm revealed the CNA used her bare hands to pick up the bread of two residents' to add condiments.</p> <p>Review of the facility Infection Control Policy, undated, revealed foods would be served using tongs, scoops, forks, spoons or spatulas to avoid manual contact.</p>	F 441	<p>created for use only in the Nursing Facility and will reflect the appropriate changes in practice. The Facility DON in conjunction with the IC nurse is responsible for compliance with these process changes.</p>



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F 441	Continued From page 18 Observation of the fluid pass on 07/21/10 10:20am, revealed CNA #4 and CNA #5 were filling glasses with ice then placing the scoop back in the ice between serving the glasses of ice to the residents. Interview with CNA #4 and #5 on 07/21/10 at 10:30am, revealed they were trained to place the ice scoop in a bin and not store the scoop in the ice as the scoop handle was not clean. Interview with the Director of the facility on 07/22/10 at 3:00pm, revealed staff were not to store the ice scoop in with the ice. She stated the staff had been trained.	F 441		



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K 000	INITIAL COMMENTS State Agency Survey was conducted on 07/22/10, in accordance with Title 42, Code of Federal Regulations, 483.70 (a) (Life Safety from fire, requirements for Long Term Care Facilities) and found the facility in substantial compliance with NFPA 101 Life Safety Code 2000 Edition.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.