

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

PRINTED: 09/07/2011
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 08/24/2011
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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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(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
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F 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted on 08/22/11-08/24/11. Deficiencies were cited with the highest scope and severity of an "F" (not being SQC) with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition. A Life Safety Code survey was conducted on 08/24/11 and found the facility not in compliance with the Life Safety Code requirements.</p> <p>F 166 SS=D 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to resolve a reported grievance for one (1) of ten (10) sampled residents. Resident #10 voiced a concern regarding the right to choose when to go to bed during the June Resident Council Meeting. There is no documented evidence the facility tried to resolve the resident's concern and determine if the resident's rights had been violated.</p> <p>The findings include: During the Group Resident Council Meeting conducted by the state surveyor, on 08/22/11 at 3:00 PM, Resident #10 stated the staff would not assist the resident to bed before 7:00 PM. The resident stated she/he had requested to go to bed</p>	F 000	<p>F 166 The NF DON communicated to Resident #10 on 8/22/11 that she could go to bed anytime she chose to do so, a notation was also added to the care plan that the resident at times prefers an earlier bedtime and all requests shall be accommodated. The NF DON will also conduct interviews with all other residents to determine similar issues by completion date and take corrective action as necessary. NF staff nurses/aides/ward clerks will be</p>	9/23/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO	(X8) DATE 9-19-11
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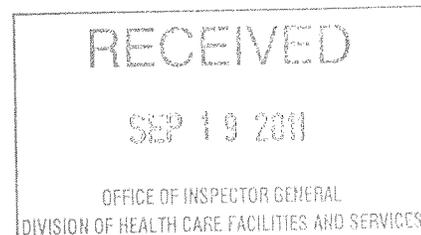
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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.

SEP 19 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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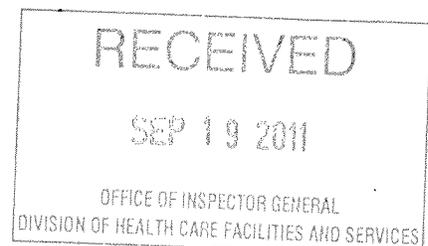
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F 166	Continued From page 1 earlier; however, the staff told the resident he/she would have to wait until after 7:00 PM. Review of the June Resident Council Meeting minutes revealed Resident #10 had informed the Activity Director that the resident was not allowed to go to bed prior to 7:00 PM. The Activity Director documented she would communicate the resident's concern to the Nursing Facility's Director. Interview with the Nursing Facility's Director on 08/24/11 at 5:05 PM revealed she had addressed the resident's concern with the staff verbally but did not document the resident's concern. She stated she had not followed up with the resident until today because she thought the issue had been resolved.	F 166	re-education by the NF DON regarding grievance process and reporting of grievances to proper personnel. Same staff will also be re-educated by NF DON regarding Resident Rights policy and future verbal corrections by NF DON will be documented. All resident grievances will be reported in quarterly quality meetings to monitor compliance with grievance policy. If less than 100% compliant, additional correctional measures will be implemented.		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the clinical record and resident shower schedule, it was determined the facility failed to accommodate two (2) of ten (10) sampled residents' preferences in regard to the time when residents wanted their showers to be given.	F 246			



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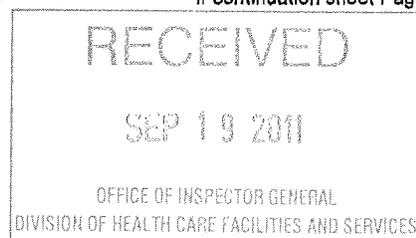
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F 246	<p>Continued From page 2</p> <p>Residents #3 and #9 were placed on a night (10 PM-6 AM) shower schedule without first asking the residents' preferences. Documentation in the clinical record revealed Residents #3 was given a shower as early as 3:00 AM.</p> <p>The findings include:</p> <p>On 08/22/11 at 3:00 PM, a Resident Council Meeting was held with the state surveyor. During the meeting, Resident #9 revealed the shower schedule had recently been changed. Resident #9 revealed his/her shower schedule was changed from days and moved to the night shift schedule. The resident stated the facility had not asked the resident's preference prior to the time change. The resident stated she/he preferred to receive showers during the day; however, the staff had awakened the resident at 5:00 AM today to receive a shower. The resident stated the shower was given at that time because the staff had to complete the assigned showers prior to end of the shift at 6:00 AM. The resident stated she/he was sleeping and would have preferred to have received the shower later.</p> <p>Review of the clinical record for Resident #9 revealed the resident has resided at the facility since 06/27/08 and each MDS (minimum data set) assessment revealed bathing at PM was never checked as a choice for the resident. The facility assessed the resident to required limited assist from staff for bathing tasks and required assistance with transfers to the shower chair.</p> <p>Review of the medical record for Resident #3 revealed the resident was admitted to the facility on 12/24/09 with diagnoses including Chronic</p>	F 246	<p>F246 Revision of the shower schedule will be conducted to accommodate resident preferences. Each resident will be interviewed regarding their preference on the timing of the showers. Interviews with residents will be documented by the NF DON. No showers will be performed on any resident between 11pm and 6am unless specifically requested by the resident. The NF DON will randomly interview residents on a monthly basis for 3 months to ensure their satisfaction with their shower schedule, any complaints from the residents will result in documentation by the NF DON and an immediate change in the shower schedule. Resident interview findings will be reported to the Quality Committee, less than 100% satisfaction will result in further measures being implemented. Future instances of staff providing showers at times other than those agreed upon by</p>	9/23/11



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F 246	<p>Continued From page 3</p> <p>Obstructive Pulmonary Disease (COPD), Alzheimer's Disease, and anxiety. Review of the daily activity preference interview completed on 06/20/11 revealed the resident indicated that it was very important to choose between a tub bath, shower, bed bath or sponge bath. Review of the nurses noted revealed on 08/15/11 the nurse documented at 3:10 AM, "resident just finished shower and shampoo". On 08/19/11 at 5:00 AM the nurse documented, "resident up at this time for shower".</p> <p>Observation and interview, on 08/22/11 at 2:20 PM, revealed Resident #3 resting in bed with oxygen per nasal cannula at 2 liters per minute. When ask about baths and showers the resident stated they get me up in the middle of the night, at one (1) o'clock in the morning.</p> <p>Observation of the shower room, on 08/23/11 at 5:15 AM, revealed an unsampled resident in the shower room with wet hair. Interview with CNA #3 (who gave the resident a shower) revealed she had just given the resident a shower at 5:00 AM. The CNA stated the resident was on the shower list to be completed on night shift. The CNA stated the shower schedule had recently been changed to include the 10 PM-6 AM shift. She indicated she would try to encourage the residents to take a shower between 10:30-11 PM if the resident was still awake, if not the resident would have to wait until this next morning at 5:00 AM. However, the CNA revealed showers have started as early as 4:45 AM.</p> <p>Interview with CNA #4, on 08/23/11 at 5:25 AM, revealed the shower schedule changed approximately one month ago. She stated she</p>	F 246	<p>the resident will be documented by the NF DON and will result in progressive disciplinary action according to facility policy.</p>



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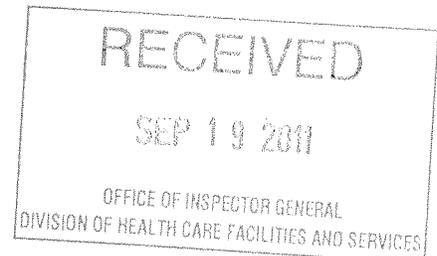
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F 246	<p>Continued From page 4 normally gives showers at 5:00 AM, but a resident can refuse the shower at that time. She stated if Resident #9 refused a shower early in the morning, then the resident's shower would be scheduled for the next shift.</p> <p>On 08/23/11 a review of the new shower schedule revealed sampled Residents #1, #3, #6, and #9 were placed on the 10-6 night shift shower schedule.</p> <p>Interview with the Nursing Facility Nursing Director, on 08/24/11 at 5:00 PM, revealed the reason the shower schedule was changed was to allow the CNAs on days and evenings more time to spend with the residents. She stated if showers were spread out among the shifts (3 per shift) it would give more time for the residents. She indicated the new shower schedule was discussed in the July staff meeting; however, she failed to ask each resident their preference. She stated residents who like to rise early were chosen and she was unaware any residents were receiving showers before 5:00 AM.</p>	F 246		
F 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the</p>	F 253	<p>F253 All doors on the NF were inspected by the Plant Manager on 8/25/11 for splintered areas and immediate repairs made as needed. The Plant Manager will inspect all doors on a monthly basis for three months and document his findings. All repair</p>	



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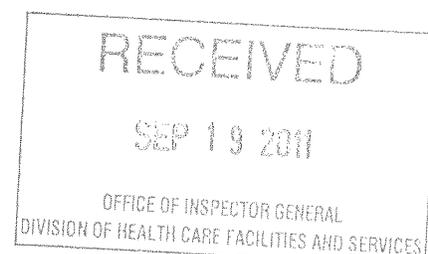
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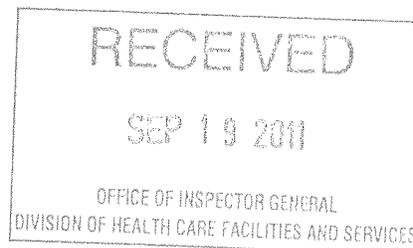
F 253	<p>Continued From page 5</p> <p>environment in a orderly and comfortable manner. The wood door to the restorative dining room was observed to have pieces of wood missing leaving a sharp splintered area. In addition, there were brown water stains observed on the ceiling tiles in Room # 209 and the restorative dining room.</p> <p>The findings include:</p> <p>Observation, on 08/22/11 at 11:00 AM and 08/23/11 at 3:30 PM, revealed the wood door to the restorative dining room was splintered with chunks of wood missing. The surface was very rough to the touch.</p> <p>Interview with the Plant Manager, on 08/23/11 at approximately 4:00 PM, revealed the facility has a work order system where staff is suppose to fill out the work order forms whenever a problem is identified. He stated he would pick up the work orders 4-6 times a day. He revealed he had not received any work orders regarding the splintered door. In addition, he stated he had conducted a routine environmental tour of the nursing facility this morning and had missed the damaged door.</p> <p>Observation during the environmental tour on 08/23/11 at 3:30 PM revealed brown water stains on the ceiling in Room # 209 and the restorative dining room.</p> <p>Interview with the Plant Manager, on 08/23/11 at approximately 4:00 PM, revealed the facility experienced roof damage from a storm a few weeks ago. He stated he had repaired the roof and stopped the water leak but had not replaced the ceiling tiles.</p>	F 253	<p>needs will be addressed upon discovery. Plant Manager will submit a report to the quarterly Quality committee to evidence all inspections and corrective actions taken.</p> <p>All ceiling tiles were also inspected on 8/25/11 by the Plant Manager, all stained or otherwise defective tiles were immediately replaced. The Plant Manager will inspect all ceiling tiles monthly for 3 months and document his findings. All repair needs will be addressed upon discovery. The Plant Manager will submit a report to the quarterly Quality committee to evidence his findings and corrective actions taken.</p>	9/28/11
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F 278 SS=E	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record, the facility failed to accurately assess and capture accurate information on the Minimum Data Set (MDS) assessment for three</p>	F 278	<p>F278 The most recent MDS assessments for residents #1 and #8 were corrected to reflect the falls that were previously omitted. On 8/25/11 all MDS assessments were compared by the NF DON to fall documentation to ensure that all resident falls were properly captured on the MDS. The BIMS assessment on resident #3 was completed on 9/7/11 and a review of every residents chart was conducted by the NF DON to ensure that all other BIMS assessments had been properly completed when applicable. The post fall assessment form has been revised to instruct staff to forward a copy to MDS Coordinator. All MDS updates will be referenced against post fall assessment forms maintained by the Risk Manager.</p>	9/23/11



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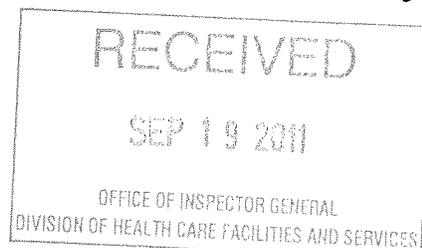
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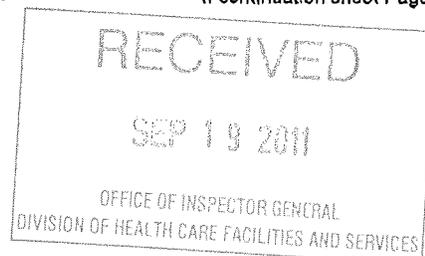
F 278	<p>Continued From page 7</p> <p>(3) of ten (10) sampled residents (#1, #3, #8). Residents #1 and # 8 had falls that were not documented on the MDS assessment and Resident #3 did not receive a cognitive Brief Interview for Mental Status (BIMS) assessment in which the resident was a candidate.</p> <p>The findings include:</p> <p>Interview with the MDS Nurse on 08/24/11 at 6:30 PM revealed the facility uses the Resident Assessment Instrument (RAI) Manual as a guide to complete the MDS Assessment.</p> <p>1. Observation of Resident #1 on 08/22/11 at 11:15 AM revealed the resident resting in bed, turned to the left side. The bed was in low position with fall mats on the right side of the bed. A Tab alarm was applied to the back of the residents shirt.</p> <p>Review of the MDS for Resident #1 revealed an Assessment Reference Date (ARD) of 08/17/11 with a signed completion date of 06/23/11. Review of section J1800, Any Falls since Admission or Prior Assessment, whichever is more recent, was coded as 0-No. Review of a fall assessment completed on Resident #1 revealed the resident had a fall on 05/30/11 with an abrasion to the upper back.</p> <p>2. Review of the MDS for Resident #8 (closed record) revealed an ARD of 03/24/11 with a signed completion date of 03/30/11. Review of section J1800, Any Falls since Admission or Prior Assessment, whichever is more recent, was coded as 0-No. Review of the nurses notes and post fall assessment revealed Resident #8 had a</p>	F 278	<p>Accuracy of the MDS updates related to resident falls will be monitored monthly by the NF DON and reported to the Quality Committee for 3 months, if less than 100% compliance additional measures will be implemented.</p> <p>Activities Director and MDS Coordinator re-educated by NF DON regarding BIMS Assessment on 8/26/11. The NF DON will review the next 6 MDS assessments or re-assessments where completion of the BIMS assessment is applicable for accuracy. The results will be reported by the NF DON to the Quality committee, if less than 100% compliance, additional measures will be implemented.</p>	
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F 278	Continued From page 8 fall on 3/24/11 at 12:50pm, with no injury. Interview with the MDS Nurse, on 08/24/11 at 6:30 PM, revealed she completed this section of the MDS. She stated she used the post fall assessments and the nurses notes in the clinical record as sources of information when completing the MDS Assessment. She stated that she was getting copies of the post fall assessments after the fall, but they made some changes to the face sheet on the incident report, and her name did not get included on the new form. She stated she had not been getting copies of all the post fall assessment but did not realize it until the first day of the survey when she filled out the Roster Matrix and they told her she had missed some falls. The MDS Nurse stated she had reviewed the nurses notes for falls but had missed the documentation regarding Residents #1 and #8's falls. She stated it was important to document the falls to ensure the care plan was updated. 3. Review of the RAI Manual 3.0 September 2010 page C-1 Cognitive Pattern revealed residents who are never/rarely understood should not be interviewed for mental status. Most residents are able to attempt the BIMS. Structured cognitive interview assist in identifying needed support and is helpful in identifying delirium behavior. Review of the MDS Assessment for Resident #3 revealed the facility had documented the resident was never or rarely understood. A BIMS was not conducted on the most recent MDS dated 06/23/11 and the annual assessment completed 12/10/11. On the 06/23/11 MDS Assessment there were additional assessment tools attached	F 278		



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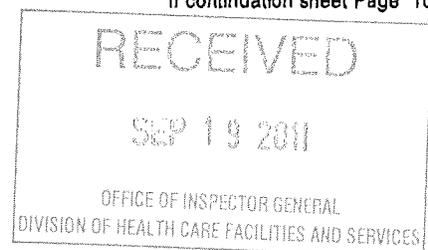
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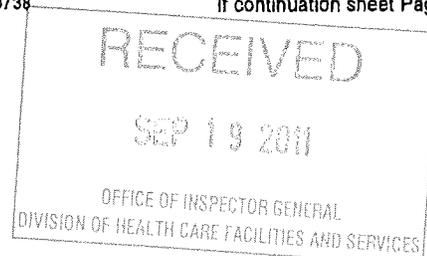
F 278	<p>Continued From page 9 to the MDS completed by the Activities Director indicating Resident #3 did qualify for the BIMS assessment.</p> <p>Observation, on 08/22/11 at 11:18 AM, revealed Resident #3 sitting up in bed. The nurse was in the room giving the resident oral medication. The resident was conversing with the nurse.</p> <p>Observation, on 08/22/11 at 12:20 PM, revealed Resident #3 was sitting up in bed eating a regular diet. The resident asked the staff to cut up a tomato.</p> <p>Interview with the MDS Nurse, on 08/24/11 at 6:30 PM, revealed she did not know why she had not completed the BIMS assessment. She stated the resident was able to communicate and the Activities Director had indicated Resident #3 should have a BIMS assessment completed. The MDS Nurse stated the purpose of the BIMS assessment was to determine cognition ability so that a Care Plan can be developed that meets the residents needs.</p>	F 278		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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</p>	F 280	<p>F280 On 8/26/11 the care plan for resident #4 was revised by the MDS Coordinator to include the physician order related to the brief. All resident care plans will be reviewed by the NF DON by the</p>	



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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 280	Continued From page 10 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review it was determined the facility failed to revised the care plan for one (1) of ten (10) sampled residents. Resident #4 developed dermatitis, and a physician's order was received to remove the incontinent brief. The facility failed to revise the care plan to reflect this change. The findings include: Review of the clinical record revealed the facility admitted Resident #4 on 03/18/11. The resident was hospitalized from May 11-18, 2011 for pneumonia. Upon return to the nursing facility on 05/18/11, the facility assessed the resident's skin and found a Stage II pressure ulcer to the left hip. In addition, the facility assessed the resident to have redness and a rash to the groin area. The facility obtained treatment and the pressure ulcer was healed on 06/16/11. The record revealed Nystain powder was ordered to be applied to the groin area on 05/19/11 for redness. On 07/03/11, the physician ordered to remove Incontinent briefs.	F 280	completion date to ensure that applicable revisions have been made according to physician orders or other pertinent data. NF DON provided re-education to the RAI Coordinator on 8/26/11 to review all pertinent data and MD orders for inclusion in the care plan when applicable. The NF DON will audit at least 6 resident care plans for accuracy and inclusion of MD orders monthly for 3 months, findings to be reported to Quality committee, if less than 100% compliance is met, additional measures will be implemented.	8/24/11



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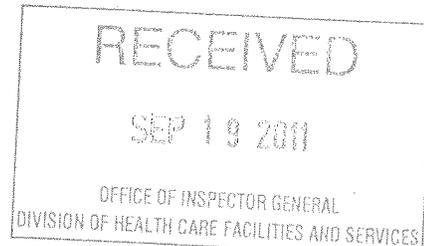
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F 280	<p>Continued From page 11</p> <p>Observation during a skin assessment performed by LPN #1, on 08/23/11 at 1:15 PM, revealed a rash on the resident's coccyx and sacrum area. The resident had no brief applied. Interview with LPN #1 at the time of the observation revealed the resident was not to wear a brief because it caused the dermatitis.</p> <p>Review of the plan of care (revision date of 07/20/11) revealed the resident was at risk for skin breakdown due to immobility and incontinence. The goal was to have no occurrence of skin breakdown. Review of the approaches revealed no instructions not to apply a brief.</p> <p>Interview with the RAI Coordinator, on 08/24/11 at 3:40 PM, revealed she did not revise the care plan when the rash was identified and the brief was ordered to be removed. She stated she had placed that information on the nursing assistant care plan; however, review of the nursing assistant care plan for August 2011 revealed no written instructions to not apply a brief. In fact, there was written instructions for the nursing assistant to apply briefs related to bowel incontinence.</p>	F 280		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p>	F 309		



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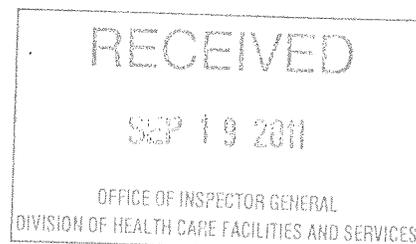
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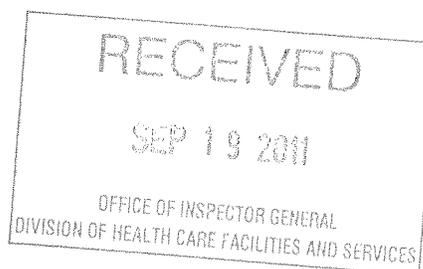
F 309	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record the facility failed to provide care and services for one (1) out of ten (10) sampled residents. Resident #3 did not receive a scheduled 5 AM dose Duoneb nebulizer treatment and the resident was told they could not receive an as needed nebulizer treatment when requested. The resident has a diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Anxiety.</p> <p>The findings include:</p> <p>Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/24/09 with diagnoses that included: pneumonia, chronic obstructive pulmonary disease (COPD), anxiety, depression, and atypical psychosis. Review of the physician orders revealed the resident had oxygen ordered for two (2) liter per minute continuous, via nasal canula and an order for Duonebs nebulizer treatments three (3) times a day, scheduled for 5:00 AM, 1:00 PM and 9:00 PM. In addition, the resident has an order for Duonebs every four (4) hours as needed. Review of the MAR (medication administration record) revealed Resident #3 had received twelve (12) additional doses (as needed) of Duoneb, in addition to the routine scheduled Duonebs in the previous fifteen (15) days.</p> <p>Review of the Comprehensive Care Plan (revision date of 06/21/11) revealed Resident #3</p>	F 309	<p>F309 The breathing treatment requested by Resident #3 was given 8/23/11 at 6:50am. All other resident charts were reviewed for other potential errors in administration documentation times by NF DON. Re-education of the Respiratory Therapy staff will be conducted by the NF DON by completion date regarding</p> <p>Medication Administration policy and accurate documentation of administration times. NF DON will monitor medication administration documentation times for at least 6 residents on a weekly basis for 3 months and report compliance with documentation to the quality committee. If less that 100% compliant, additional measures will be implemented.</p>	9/23/11
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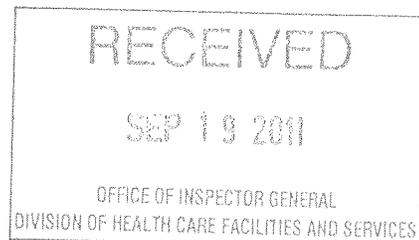
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F 309	<p>Continued From page 13</p> <p>was unable to complete any activities of daily living without the assistance of staff related to shortness of air associated with COPD. In addition, Resident #3 was care planned for short of breath upon exertion or when under stress secondary to advance COPD.</p> <p>Observation of Resident #3, on 08/23/11 at 6:25 AM, revealed the resident lying in bed with oxygen infusing at 2 liters per minute per nasal canula. The resident asked the nurse for a "breathing treatment". At that time the Licensed Practical Nurse (LPN #2) reviewed the medication record for Resident #3 and told the resident a breathing treatment was administered about an hour ago and another breathing treatment could not be given at that time.</p> <p>At 6:50 AM on 08/23/11, a Respiratory Therapist was observed administering a breathing treatment to Resident #3.</p> <p>Interview with the Respiratory Therapist, on 08/23/11 at 6:50 AM, revealed she had given Resident #3 a Duoneb treatment at 3:30 AM but signed it off as the 5 AM Duoneb scheduled treatment. She acknowledged she should have document the time the treatment was given so the nursing staff would be aware of when the resident could have the next treatment. She stated it was important to document the correct time because Resident #3 had an order for a Duoneb treatment every four hours, as need, in addition to the routine scheduled Duoneb treatment.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 08/23/11 at 7:45 AM, stated it was important</p>	F 309		



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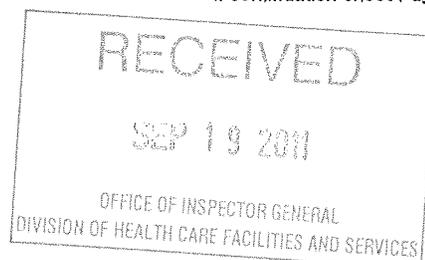
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F 309	Continued From page 14 the Respiratory Therapist documented the correct time of the medication administration because that could affect when Resident #3 could receive the next Duoneb breathing treatment.	F 309		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy the facility failed to provide proper sanitation and safe food handling practices for the prevention of foodborne illness. Observation during the initial tour of the kitchen revealed three (3) out of four (4) containers of opened fruit were expired, and the meat slicer, ready for use, had dried food particles on the blade. The findings include: Review of facility policy for infection prevention and control in Nutritional Services (no effective date or revision date) revealed all equipment shall be thoroughly cleaned after each use. Food not in its original container shall be stored....covered, labeled and dated.	F 371	F371 On 8/22/11 the outdated fruit found in the dietary department were disposed of and the meat slicer was disassembled and cleaned by Dietary Manager. Procedure regarding inspection of outdated food items has been revised to require that the evening shift staff will inspect all open food items for expiration each day before the end of the shift as well as another inspection by day shift for expired items. Expired items will be removed upon inspection and discarded. Education and in-service for the dietary staff on the revised procedure as well as proper cleaning of the meat slicer was conducted on 9/12/11 by the Dietary Manager and the Plant Manager. Monthly inspections of these issues will be conducted by the Infection Control nurse for 3 months and findings reported to	9/23/11



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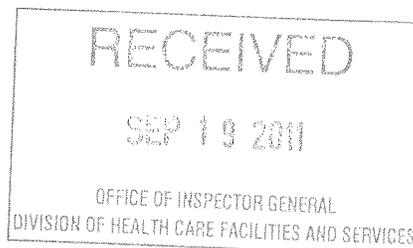
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F 371	Continued From page 15 Observation, on 08/22/11 at 8:30 AM, revealed three (3) containers of crushed pineapple, pears, and mandarin oranges dated 08/20/11. Observation of the meat slicer revealed the back of the blade had dried food particles. Interview with dietary aide #1 during the initial tour, on 08/22/11 at 8:30 AM, revealed the three (3) containers of fruit should have been discarded as they were expired. She stated the meat slicer was ready for use and she did not know what the food substance was or how long it had been there. Interview with the Dietary Manager, on 08/23/11 at 1:10 PM, revealed a dietary aide is scheduled to check the refrigerator and freezer every Monday for outdated items. Any outdated food items are to be discarded. She indicated that task had not yet been completed on 08/22/11 at 8:30 AM. The Dietary Manager stated she needed to revise the system to ensure outdated food items are checked daily. The Dietary Manager stated maintenance usually takes apart the meat slicer, cleans the blade and parts, then puts it back together.	F 371	the Quality Committee. If less than 100% compliant, additional measures will be implemented. Handrails in question were tightened immediately, day of survey. Plant Manager will conduct monthly inspections of handrails on NF for 3 months and report findings to the Quality committee, if less than 100% compliant, additional measures will be implemented.	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure handrails were secure on each side of the hallway.	F 468	F468 Handrails in question were tightened immediately, day of survey. Handrails are routinely inspected however the rails in question had been missed in most recent inspection. Plant Manager will conduct random inspection of	



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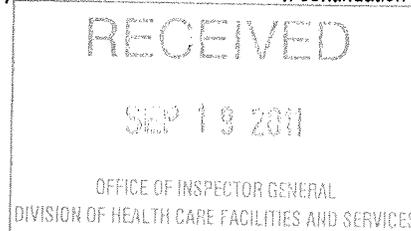
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F 468	Continued From page 16 The findings include: Observation, on 08/23/11 at 11:00 AM and 08/24/11 at 3:55 PM, revealed the handrail outside Rooms # 209, 210, and 213 were loose. In addition, the handrail outside the cafe was found to be loose. Interview with the Plant Manager, on 08/23/11 at 4:00 PM, revealed he checks the handrails weekly. He stated he checked the handrails that morning, found several loose, and was in the process of fixing the handrails.	F 468	handrails on NF weekly for 6 months. Findings will be reported to the Quality Committee, if less than 100% compliant, additional measures will be implemented.	9/23/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy, and review of the medical record, the facility failed to ensure a medication prescribed by a physician was transcribed correctly for two (2)	F 514	F514 The order in question for Resident #3 was clarified with the physician and corrected by the NF DON on 8/23/11. The requested "breathing treatment" for resident # 5 was also administered on 8/24/11. On 8/25/11 and 8/26/11 the NF DON reviewed all resident charts for accuracy and completion of medication orders. All NF nursing staff and ward clerks will be re-educated by the NF DON by correction date regarding the physician order implementation policy with emphasis on 1) transcription of physician orders,	



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F 514	<p>Continued From page 17</p> <p>of ten (10) sampled residents. Resident #5 had an order for PF Tears (Genteal) written on 01/18/11 that was not complete with instructions on how many drops or which eye the drops were to be administered. In addition, Resident #3, did not receive a Duoneb breathing treatment in a timely manner due to inaccurate documentation.</p> <p>The findings include:</p> <p>Review of the facility policy Physician Order Implementation revised 02/11/11, revealed when a medication order is unclearor the order is questionable, the nurse is to immediately contact the physician for clarification. In addition, Physicians orders will be processed and implemented in a timely manner, to ensure a residents needs... are met.</p> <p>1. Observation, on 08/23/11 at 9:45 AM, revealed Registered Nurse (RN) #1 prepared to give an eye drop medication to Resident #5. RN #1 discovered the medication order for PF Tears Genteal did not include which eye to instill the drop or how many drops were to be instilled.</p> <p>Interview with RN #1, on 08/23/11 at 9:45 AM, revealed the medication was not a complete order and needed clarification. The nurse did not give the medication at that time.</p> <p>Review of the medical record of Resident #5 revealed a physician order was received for PT Tears Genteal on 01/18/11. The medication was transcribed as written: PT Tears Genteal QID (4 times a day). Review of the clinical record revealed no documentation the facility called the physician to clarify the order.</p>	F 514	<p>2) process for order clarification. Also, re-education for Pharmacy staff regarding regulations for Pharmacist review of all medication orders for accuracy and completion will be conducted by the CNO by the completion date. NF DON will audit at least 6 resident medication orders compared to the MAR for accuracy monthly for 3 months and report findings to the Quality Committee, if less than 100% compliant, additional measures will be implemented.</p>	9/23/11



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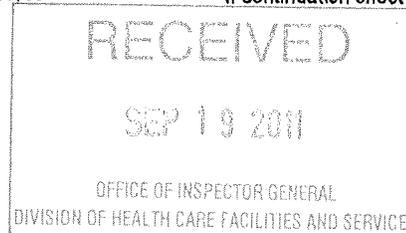
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F 514	<p>Continued From page 18</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/24/11 at 8:25 AM, who had administered medications in the past to Resident #5, revealed the order for the eye drops was not complete because it did not specify which eye or how many drops should be administered. LPN #1 stated she just assumed it was the same eye as the other eye medications were administered.</p> <p>Interview with LPN #2, on 08/24/11 at 3:15 PM, revealed the medication records are for a fifteen day time period. She stated every fifteen days the medication orders are reviewed by the nurse to ensure the medication orders are current and correct before replacing with the new medication record. LPN #2 stated the order for the PF Tears for Resident #5 was incorrect and the physician should have been called for a clarification.</p> <p>Interview with the Director of Nursing (DON), on 08/24/11 at 3:30 PM, revealed the system for receiving new physician orders was the following: when a physician order is received, the ward clerk transcribes the order onto the medication record or treatment record. The nurse will then review the order and transcribe the order onto a three part form. The pink copy goes in the medical record temporality, the white copy goes to the physician to sign and the yellow copy goes to the pharmacy. Once the white copy is signed by the physician, it replaces the pink copy on the chart. The DON stated there was a system in place and this incomplete order should have been caught. She stated it just got missed.</p> <p>Interview via telephone with the Pharmacist, on 08/24/11 at 6:30 PM, revealed a new written order</p>	F 514		
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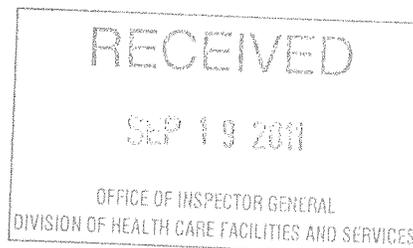
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NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143
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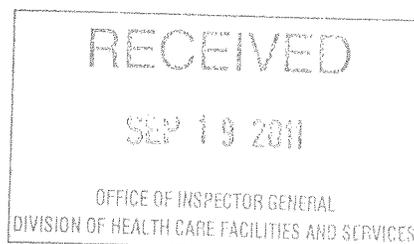
F 514	<p>Continued From page 19</p> <p>is only reviewed one time, upon receipt. He stated the monthly pharmacy reviews generally only include pharmacy recommendations for drug interactions, and gradual dose reduction. He stated he could not explain why pharmacy did not identify the incomplete eye drop medication order without looking at the chart.</p> <p>2. Review of the medical record for Resident #3 revealed the facility admitted the resident on 12/24/09 with diagnoses that included: pneumonia, chronic obstructive pulmonary disease (COPD), anxiety, depression, and atypical psychosis. Review of the physician orders revealed the resident had oxygen ordered for two (2) liter per minute continuous, via nasal canula and an order for Duonebs three (3) times a day, scheduled for 5:00 AM, 1:00 PM and 9:00 PM. In addition, the resident has an order for Duonebs every four (4) hours as needed.</p> <p>Observation of Resident #3, on 08/23/11 at 6:25 AM, revealed the resident lying in bed with oxygen infusing at 2 liters per minute per nasal canula. The resident asked the nurse for a "breathing treatment". At that time the Licensed Practical Nurse (LPN) #2 reviewed the medication record for Resident #3 and told the resident a breathing treatment was administered about an hour ago and another breathing treatment could not be given at the time.</p> <p>Observation, on 08/23/11 at 6:50 AM, revealed the Respiratory Therapist giving Resident #3 a breathing treatment.</p> <p>Interview with the Respiratory Therapist, on 08/23/11 at 6:50 AM, revealed she had given the</p>	F 514		
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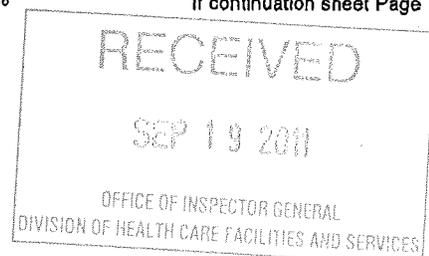
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F 514	Continued From page 20 Resident #3 a Duoneb treatment at 3:30 AM but signed it off as the 5:00 AM Duoneb treatment. She acknowledged she should have document the time the treatment was given so the nursing staff would be aware of when the resident could have the next treatment. She stated it was important to document the correct time because Resident #3 had an order for a Duoneb treatment every four hours as need in addition to the routine scheduled Duoneb treatment. Interview with Licensed Practical Nurse (LPN) #2, on 08/23/11 at 7:45 AM, stated it was important the Respiratory Therapist documented the correct time of the medication administration because that could affect when Resident #3 could receive the next Duoneb treatment.	F 514		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520	F520 Quarterly quality committee meetings will not be held without the presence of at least one physician. If the physician schedule to attend cannot be present, the meeting will be re-scheduled until another time. Sign in sheets to evidence the physician's presence and participation will be monitored quarterly by the CNO for 6 months.	9/23/11



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F 520	<p>Continued From page 21 compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the QA (quality assurance) meeting signature sheet revealed the facility failed to have a QA committee consisting of the required members. The facility failed to ensure a physician representative was present at each quarterly QA meeting.</p> <p>The findings include:</p> <p>Interview with the Administrator and the Chief Nursing Officer (CNO), on 08/24/11 at 6:00 PM, revealed the QA committee meets quarterly. The Administrator stated the Medical Director is invited to each quarterly QA meeting but does not always attend. The facility does not obtain another physician representative. The CNO stated the QA minutes are shared with the Medical Director later and he gives input into decision-making. The Medical Director is an outside contract employee and makes independent decisions on whether he will be present at the QA meetings.</p> <p>Review of the signature sheet for the QA meeting held on 06/01/11 revealed no physician representative was present.</p>	F 520		



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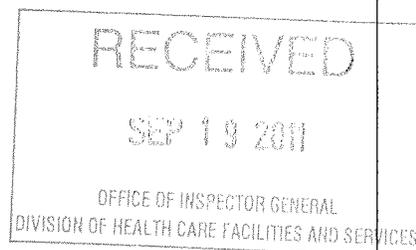
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NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) story, Type I Unprotected</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type I generator installed in 1985. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 08/24/11, and concluded on 08/24/11. Breckenridge Memorial Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighteen (18) beds with a census of eighteen (18) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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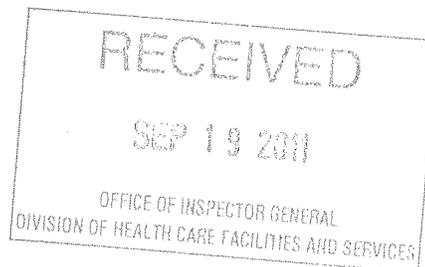
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Moser</i>	TITLE CEO	(X8) DATE 9-19-11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing 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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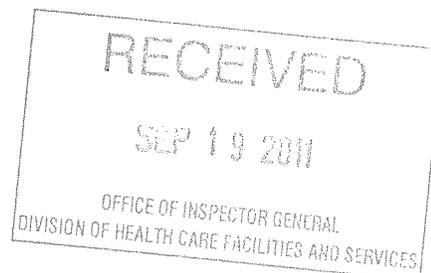
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K 000	Continued From page 1 Fire)	K 000		
K 070 SS=D	Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for eighteen (18) beds with a census of eighteen (18) on the day of the survey. The findings include: Observation, on 08/24/11 between 12:15 PM and 12:30 PM, with the Maintenance Director revealed portable space heaters located in the Utilization Review Room, and behind the Nurses Station. Interview, on 08/24/11 between 12:15 PM and 12:30 PM, with the Maintenance Director revealed, they were unaware the heaters did not meet the requirements of the code.	K 070	K070 Portable space heaters have been removed from the Nursing Facility. Plant Manager will inspect for the presence of prohibited heaters on a monthly basis for 3 months and will report his findings to the Quality committee. Less than 100% compliance will require immediate corrective action, upon discovery by the Plant Manager and NF DON.	9/23/11



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K 070	Continued From page 2	K 070		
K 154 SS=F	<p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>This STANDARD is not met as evidenced by: Based on interview and facility policy and procedure review, the facility failed to develop a fire watch policy to ensure the safety of occupants of the building in case the sprinkler system is out of service. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for eighteen (18) beds with a census of eighteen (18) on the day of the survey.</p>	K 154	<p>K154 Fire Watch policy was developed on 8/24/11. In-service / education for employees will be conducted by 9/23/11 by the Risk Manager. The policy will be made available to all employees and signatures of acknowledgement of policy content will be presented to the Quality committee for review.</p>	9/23/11



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K 154	Continued From page 3 The findings include: Policy and Procedure review, on 08/24/11 at 12:55 PM, with the Maintenance Director revealed the facility had no written fire watch policy. Interview, on 08/24/11 at 12:55 PM, with the Maintenance Director revealed he thought the facility had a written policy. Reference; NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. NFPA 101 LIFE SAFETY CODE STANDARD	K 154		
K 155 SS=F	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on interview and fire watch review, the facility failed to develop a fire watch policy to	K 155	K155 Fire Watch policy was developed on 8/24/11. In-service / education for employees will be conducted by 9/23/11 by the Risk Manager. The policy will be made available to all employees and signatures of acknowledgement of policy content will be presented to the Quality committee for review.	9/23/11



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K 155	<p>Continued From page 4</p> <p>ensure the safety of occupants of the building in case the fire alarm system is out of service. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is licensed for eighteen (18) beds with a census of eighteen (18) on the day of the survey.</p> <p>The findings include:</p> <p>Policy and Procedure review, on 08/24/11 at 12:55 PM, with the Maintenance Director revealed the facility had no written fire watch policy.</p> <p>Interview, on 08/24/11 at 12:55 PM, with the Maintenance Director revealed he thought the facility had a written policy.</p> <p>Reference; NFPA 101 (2000 edition) 9.6.1.8*</p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p>	K 155		

