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 MASSACHUSETTS DEPARTMENT OF HEALTH AND SERVICES

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

PRINTED: 04/23/2015
 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 04/16/2015
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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	INITIAL COMMENTS	F 000		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure two (2) of eight (8) sampled residents, Resident #1 and #3, and one (1) of two (2) unsampled residents, Unsampled Resident A had complete and accurate clinical records. Resident #1 and Unsampled Resident A had a Do Not Resuscitate (DNR) status on their red clinical charts and a Full Code status on their blue finance records. Both Resident #1 and Unsampled Resident A had Advanced Directives</p>	F 514	<p>IMMEDIATE ACTION: On April 14, 2015, all 18 resident charts were audited for correct filing of monthly orders and that advanced directive stickers on the maroon clinical charts and blue financial charts matched the advanced directives of the resident. This was done by the Director of Nursing.</p> <p>PLAN: All charts will be free from filing errors and DNR stickers will be placed correctly on charts in accordance with resident advanced directives in place.</p> <p>PROCEDURE: On May 5th, 2015, finance charts will be combined with maroon clinical charts under the social services tab by the Director of Nursing. April 30th, 2015 policy was reviewed and updated by the Director of Nursing as well as the Chief Nursing Officer and forwarded to QA for approval. On May 5th, 2015, Ward Clerks, Activity Director, MDS Coordinator, RN's, LPN's and C.N.A.'s were provided with education by the Director of Nursing regarding the process change and policy updates.</p>	Completed By: May 10, 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Angela Patman* TITLE: X CEO (X6) DATE: 4-18-15

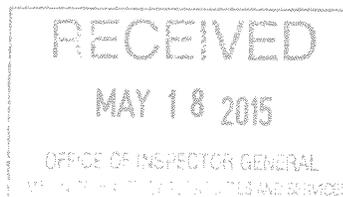
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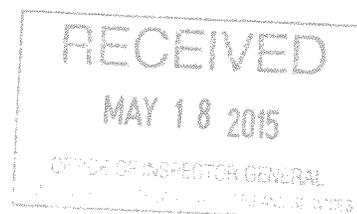
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F 514	<p>Continued From page 1 for a DNR. In addition, Resident #3's clinical record contained Unsampled Resident B's physician orders for the month of April 2015.</p> <p>The findings include:</p> <p>Review of the Clinical Records Policy, revised January 2014, revealed the clinical records would be complete, accurate to documentation, readily assessable, and systematically organized.</p> <p>1. Review of Resident #3's clinical record, revealed Resident #3's Physician Orders for the month of April 2015 was actually Unsampled Resident B's Physician Orders. Resident #3's Physician Orders for the month of April 2015 was not located in the medical record.</p> <p>Review of Resident #3's, Medication Administration Record (MAR), revealed Resident #3's medications were the correct medications prescribed by the primary physician. Thus, Resident #3 received the correct treatments and medications.</p> <p>Interview with the Ward Clerk, on 04/16/15 at 2:50 PM, revealed about a month and a half ago, the responsibility of placing the orders in the residents medical record was switched from the Ward Clerk to the nursing staff. The Ward Clerk stated anyone who placed the signed Physician Orders into the residents medical record was supposed to initial and date the Physician Order.</p> <p>Review of Unsampled Resident B's Physician Orders, revealed no initial or date of the person who placed the orders into Resident #3's record.</p>	F 514	<p>MONITOR: All 18 resident charts will be audited monthly by the DON. Audits will be reported to QA for two consecutive quarters. Audits may be discontinued after this time if there is 100% compliance.</p> <p>RESPONSIBLE PARTY: Director of Nursing,</p>		



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F 514	<p>Continued From page 2</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/16/15 at 2:16 PM, revealed at the end of the month, two nurses would verify the orders were correct, then date and sign the orders to show the orders were verified. The nurse who received the signed copy from the physician would initial and date the orders to verify she had placed the orders in the medical record. LPN #1 stated if a resident received the wrong physician orders, wrong medication could be given, the wrong doctor or power of attorney could be called. LPN #1 stated giving the wrong medication could affect a residents allergy and possibly harm the resident.</p> <p>Interview with the Director of Nursing (DON), on 04/16/15 at 2:31 PM, revealed nurses double checked the orders and the ward clerks placed the orders in the residents records. The DON stated she had had some problems with the medical records not being accurate and being filed in the wrong resident record. No adverse outcomes had been identified. The DON stated she monitored to ensure the orders matched the right resident. The DON stated if a resident had the wrong orders on his/her record, the resident was at risk of the doctor receiving the wrong information from a nurse and then the doctor giving the wrong order, which could lead to the resident possibly passing away. The DON further stated, Resident #3's record as it was, was not complete and accurate to Resident #3's status.</p> <p>Interview with the Chief Executive Office (CEO), on 04/16/15 at 2:54 PM, revealed after reviewing Resident #3's record, the record was not complete and accurate to Resident #3's status. The CEO stated she was aware there were some problems with filing and there was some</p>	F 514		



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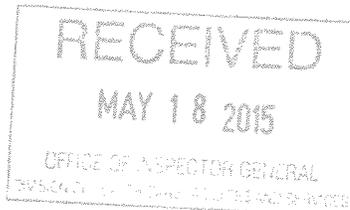
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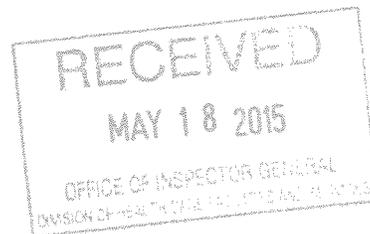
F 514	<p>Continued From page 3</p> <p>re-education completed for the staff in regards to the importance of being careful and filing correctly. Their process for placing the physician orders in the residents record, was when the physician signed the orders and it was sent back, the nurse would put the appropriate orders in the chart. The CEO stated if multiple safety checks failed and they were just looking off of the chart, then yes their could be harm to the resident.</p> <p>2. Review of Resident #1's clinical record revealed the facility admitted the resident on 05/01/12. The resident had a Living Will that was dated 2008 and an Advanced Directive for no Cardiopulmonary Resuscitation (CPR) and executed a DNR order on 05/01/12.</p> <p>Review of the records revealed the resident had two charts. The blue chart was for finance and the red chart was the clinical record. The blue chart had a CPR sticker and the red chart had a DNR sticker.</p> <p>3. Review of Unsampled Resident A's clinical record revealed the facility admitted the resident on 07/05/12. Review of the Advanced Directive form revealed the resident executed a DNR on 05/02/13 and indicated she/he did not want CPR. Review of the blue chart for the resident revealed a sticker for CPR and the red chart had the DNR.</p> <p>Interview with the DON, on 04/15/15 at 4:05 PM, revealed the facility used two charts for each resident. The blue chart was for finance and the</p>	F 514		
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F 514	Continued From page 4 red chart was the clinical record. She stated the code status was correct on the red clinical chart, but not the blue finance chart. She stated she did not know who had put the CPR sticker on the outside of the blue chart or know how it happened. She revealed the nurse who received the code status order from the physician and the Ward Clerk was responsible for placing the code status stickers on the charts. Continued interview with the DON revealed she had not conducted any audits of the charts to ensure the code status of each resident was correct. She stated the nurses would normally go by the clinical record, but she could see if the blue chart said something different, it could result in the resident being coded against their wishes. Interview with the Ward Clerk, on 04/15/15 at 4:20 PM, revealed she was unaware that Resident #1's and Unsampled Resident A's blue chart indicated the resident was a full code and the clinical chart had the resident as a DNR. The Ward Clerk stated when the nurse obtained the physician's order for the code status of a resident, she would see the order and place the correct sticker on the charts. She doesn't know how the different stickers got on the charts. She stated she did not review the charts to ensure the code stickers matched for the clinical and finance charts. She continued to say she was only responsible for placing the stickers on the charts upon receipt of the physician's order. She stated there could have been another code status order after the stickers were placed on the charts. However, she did not check the charts to ensure they matched.	F 514			
F 520	483.75(o)(1) QAA	F 520			



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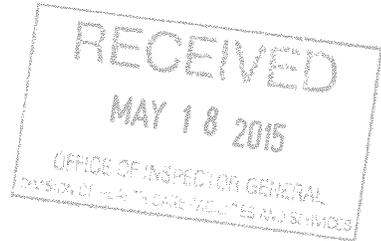
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F 520 SS=D	<p>Continued From page 5</p> <p>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>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.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the 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, policy review, and review of the QA Attendance Sign-In sheets, it was determined the facility failed to ensure the Medical Director documented his/her signature that they met at least quarterly for two (2) of four (4) meetings with the facility to identify, implement and evaluate any identified concerns.</p>	F 520	<p>PLAN: Quarterly Quality Committee meetings will not be held without the presence of the medical director. If the medical director cannot attend, the meeting will be rescheduled for a date and time that they will be able to attend.</p> <p>PROCEDURE: On April 23, 2015, DON updated the Medical Director on the information received during the survey regarding the regulatory requirement that the Medical Director provide his own signature on the sign in sheets.</p> <p>MONITOR: Sign in sheets to evidence the medical director's presence and participation will be monitored quarterly by the CNO for 6 months. If there is 100% compliance after 6 months this monitor may be discontinued.</p> <p>Responsible Party: Director of Nursing and Chief Nursing Officer</p>	Completed by: May 10, 2015
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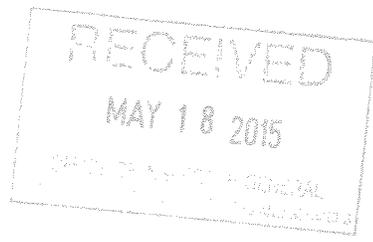
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F 520	<p>Continued From page 6</p> <p>The findings include:</p> <p>Review of the Quality Assurance (QA) Policy, reviewed January 2014, revealed the purpose was to continue to improve the quality and safety of patient care and services. The policy did not outline what was expected of the Medical Director or how often the Medial Director was to meet with the Quality Assurance Committee.</p> <p>Review of the QA Attendance Sign-In sheet, dated for 04/25/14, revealed the Medical Director signed the Attendance Sign-In sheet.</p> <p>Review of the QA Attendance Sign-In sheet, on 07/22/14, revealed the Medical Director did not sign the Attendance Sign-In sheet, but the Director of Nursing (DON) signed the Medical Directors signature for proof of attendance.</p> <p>Interview with the DON, on 04/16/15 at 2:55 PM, revealed she had to sign the Medical Director signature because the Medical Director told her to sign the QA Attendance Sign-In sheet. She stated she approached him during his lunch to sign the Attendance Sheet and the Medical Director told her to sign.</p> <p>Review of the QA Attendance Sign-In sheet, on 10/24/14, revealed the Medical Director signed the Attendance Sheet.</p> <p>Review of the QA Attendance Sign-In sheet, on 01/21/15, revealed the Medical Director did not sign the Attendance sheet, nor was it signed by the DON of proof of the Medical Directors attendance.</p> <p>Interview with the Medical Director, on 04/16/15</p>	F 520		
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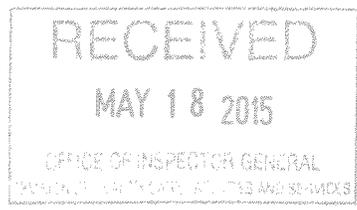
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F 520

Continued From page 7
at 2:48 PM, revealed each of the department heads met in the conference rooms. Reports were given and he helped to resolve the problems identified. The Medical Director stated he remembered missing one meeting, but did not remember which meeting. The Medical Director stated he did not remember telling the DON to sign his name on the Attendance sheet, but then thought maybe he did and agreed that he should sign his own signature.

Interview with the Chief Executive Office (CEO), on 04/16/15 at 3:28 PM, revealed she thought the Medical Director had attended the QA meetings. The CEO stated if you did not place the Attendance Sign-In sheet in front of the Medical Director, he would not sign the sheet. The CEO stated she was not aware the Medical Director had asked the DON to sign for his attendance and would not approve for the DON to sign for the Medical Director. The DON did not know that her signing for the Medical Director was a concern. The CEO stated she remembered a few years ago having this same problem with the Medical Director and updating the QA policy. The CEO stated the Policy needed to be revised to ensure the frequency and a directive was given for the Medical Director. The CEO could not provide a more up-to-date policy.

F 520



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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, 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type I (222)</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 II generator. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 04/15/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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