

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS A standard health and an abbreviated survey investigating KY#14744 were conducted 07/21/10 - 07/22/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition. KY#14744 was found to be substantiated. A Life Safety Code survey was conducted on 07/22/10 and found the facility in compliance with Life Safety Code requirements.	F 000		
F 153 SS=B	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to inform residents of their right upon an oral or written request, to access all records pertaining to himself/herself including current records within twenty-four (24) working hours and after receipt of his/her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two (2) working days advance notice to the	F153	Resident's rights policy and informational hand out will be revised to include right to access and purchase copies of the resident's record. Revised form will be made available to all current residents as well as all new admissions. Nursing facility nursing and aide staff will be educated regarding the change in policy by the Nursing Facility DON. The Facility DON or her designee will conduct monthly audits on 100% of	8-27-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Michael Cooper* TITLE *CEO* (X8) DATE *8-20-10*

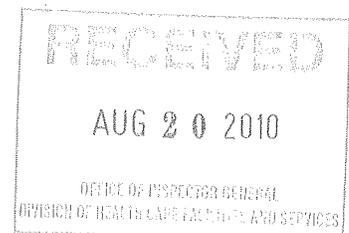
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
AUG 20 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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

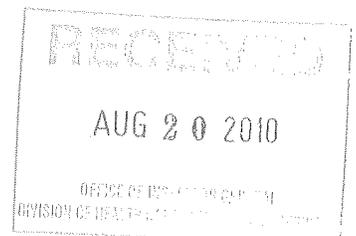
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, 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)	(X5) COMPLETION DATE
F 153	Continued From page 1 facility. The findings include: Review of the facility's Resident Rights statement provided to residents on admission to the facility revealed the facility failed to provide evidence that residents were informed of their right to access/purchase copies of their records. Interview with the Director of the facility revealed she was responsible for the admission process and review of Resident Rights for residents and there was no information provided to residents regarding access to their records. She stated she was not aware of the requirements.	F 153	new admissions for three consecutive months to ensure that all residents have received and acknowledged receipt of revised rights hand out. If 100% compliance has not been achieved in three months, the audit period will extend to six months. The results of the monthly audits will be reported to and reviewed by the CNO and Quality Assurance Committee. The Facility DON will be responsible for ensuring compliance with this process.	
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system	F 159		



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)	(X5) COMPLETION DATE
F 159	<p>Continued From page 2</p> <p>that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop a system to deposit resident funds in excess of fifty (50) dollars in an interest bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account.</p> <p>The findings include:</p> <p>Review of the facility's Resident Funds Policy, undated, revealed the facility would secure</p>	F159	<p>Resident's rights policy and informational handout will be revised to include right to request the facility to hold, safeguard, manage and account for personal funds of the resident deposited with the facility. Funds in excess of \$50 dollars shall be deposited in an interest bearing account separate from the facility's accounts. The resident shall receive quarterly statements and statements will be available at any time upon request. The facility will notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 in writing. The revised form will be made available to all current residents as well as all new admissions. Nursing facility nursing and CNA staff will receive education regarding the change in policy from the Nursing Facility DON. The Facility DON or her designee will conduct monthly audits of 100% of new admissions to ensure all residents have received and acknowledged receipt of revised rights hand out. If 100% compliance is not obtained within three months, the audit period will</p>	8-27-10



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

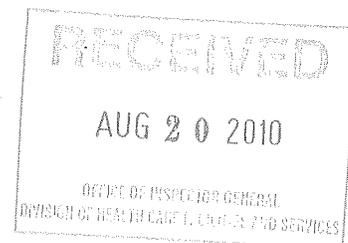
PRINTED: 08/04/2010
FORM APPROVED
OMB NO. 0938-0391

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

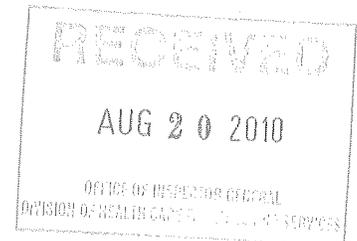
F 159	Continued From page 3 monies in the hospital safe if requested by the resident/responsible party. The facility was unable to provide evidence of a system to manage resident funds in excess of fifty (50) dollars in an interest bearing account. Interview with the Director of the facility on 07/22/10 at 3:00pm, revealed she completed the resident admissions which included a review of Resident Rights. She stated the facility would place residents' monies in the hospital safe if requested to do so. She stated residents were requested not to keep more than two (2) dollars with them. She stated there was no system or policy in place to deposit resident funds in excess of fifty (50) dollars in an interest bearing account. She stated she was not aware of the requirements. Interview with Resident #5 on 07/22/10 at 9:15am revealed she had no knowledge regarding resident funds and how the facility would handle resident monies.	F 159	be extended to six months. All audit findings will be submitted to the CNO and Quality Assurance Committee for review. The committee will meet monthly for the duration of the audit period. The facility DON is responsible for compliance with this process change.	
F 166 SS=B	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to inform residents orally and in writing regarding their right to prompt efforts by the facility to resolve grievances.	F166	Resident's rights policy and informational hand out will be revised to include right to prompt resolution of any grievance the resident may have including those with respect to the behavior of other residents. Revised form will be made available to all current residents as well as all new admits. Nursing Facility nursing and aide staff will be educated on the change in policy by the Facility DON	8-27-10



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

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

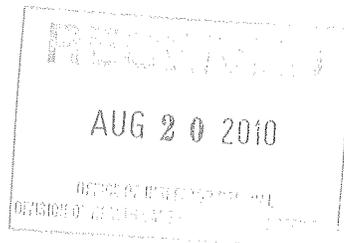
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, 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)	(X5) COMPLETION DATE
F 166	Continued From page 4 The findings include: Review of the facility's statement of Resident Rights provided at admission, revealed no evidence to show the facility informed residents orally and in writing that grievances would be promptly addressed and the facility would keep the resident appropriately apprised of their progress toward resolution. Interview with the Director of the facility on 07/22/10 at 3:00pm, revealed there was no information provided to the resident by the facility to inform the resident that grievances would be acted upon promptly and the resident would be appropriately apprised of the facility's progress towards resolution. She stated she was not aware of the requirements. Interview with the Director of the facility on 07/22/10 at 3:00pm, revealed residents were informed of their right to file a grievance; however, there was no notification of how the grievance would be handled by the facility nor providing the resident with information regarding the resolution.	F 166	The Facility DON or her designee will conduct monthly audits on 100% of all new admissions to ensure all residents have received and acknowledged receipt of revised rights hand out. If 100% compliance is not obtained within the three month time period, the audit period will be extended to six months. The Facility DON will report her audit results to the CNO and Quality Assurance Committee for review. The Facility DON is responsible for compliance .	
F 176 SS=B	Interview with Resident #5 on 07/22/10 at 9:15am revealed the resident was not aware of the Resident Right to access clinical records. 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(II), has determined that this practice is safe.	F176	Resident's rights policy and informational hand out will be revised to include right to self administer medications when the interdisciplinary team has determined that this practice is safe. Revised form will be made	8-27-10



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)	(X5) COMPLETION DATE
F 176	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to inform residents upon admission, orally and in writing, of their right to self-administer medications. The findings include: Review of the Resident Rights provided to residents when admitted to the facility revealed no evidence the facility informed the residents of their right to self-administer medications. Interview with the Director of the facility on 07/22/10 at 3:00pm revealed self-administration of medications was not reviewed with residents when admitted to the facility. She stated she was not aware of the requirements. Interview with Resident #5, on 07/22/10 at 9:15am, revealed the resident had no knowledge regarding self-administration of medication.	F 176	available to all current residents as well as all new admits. Nursing Facility nursing and aide staff will be educated on the change in policy by the Facility DON. The Facility DON or her designee will conduct monthly audits for three consecutive months on 100% of all new admissions to ensure all residents have received and acknowledged receipt of revised rights hand out. If 100% compliance is not reached, the audit period will extend to six months. The Facility DON will report her audit results to the CNO and Quality Assurance Committee for review. The Quality Assurance Committee will meet monthly for the duration of the monthly audits. The Facility DON is responsible for compliance .	
F 203 SS=E	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section	F 203		



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

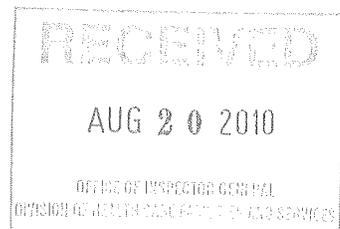
PRINTED: 08/04/2010
FORM APPROVED
OMB NO. 0938-0391

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

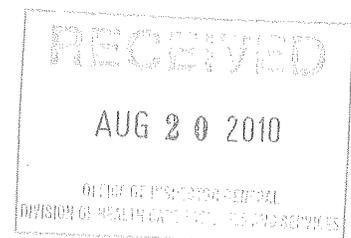
F 203	<p>Continued From page 6</p> <p>must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F203	<p>A new transfer policy and notice of transfer form will be made available to all current residents and new admissions. The notice of transfer will include all data required by law and will be provided to patients as soon as possible prior to the transfer. In case of emergent transfer the notice of transfer will be completed and will accompany the patient to the destination setting. All Nursing Facility nursing and aide staff will be educated to this change in process by the Facility DON. The Facility DON or her designee will conduct monthly audits on 100% of all admitted and transferred patients for three consecutive months to ensure compliance with this process. If 100% compliance is not achieved in three months the audit period will be extended to six months. 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>	8-27-10
-------	---	------	---	---------



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

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

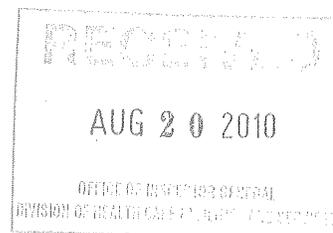
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, 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)	(X5) COMPLETION DATE
F 203	<p>Continued From page 7</p> <p>Based on interview and record review, it was determined the facility failed to provide two (2) of eight (8) sampled residents (#4 and #8) with a Notice of Transfer, specifying the reason for the transfer; the resident's right to appeal the transfer; the name, address, and a telephone number of the state long term Ombudsman, when residents were admitted or when they required a transfer to a hospital for urgent medical needs.</p> <p>The findings include:</p> <p>Review of the facility's Admission Policies, undated, revealed a notice of transfer would be provided to residents prior to all transfers and discharges except in emergencies. There was no evidence to show the facility provided residents with a Notice of Transfer which included; the reason for transfer; a statement that the resident has the right to appeal the action to the State; name, address, telephone number of the State long term Ombudsman.</p> <p>Review of the clinical record for Resident #4 revealed the resident was admitted to the facility with diagnoses of Chronic Renal Failure, Congestive Heart Failure, and Anxiety. On 05/14/10, the resident experienced urgent medical concerns and was transferred to the hospital and admitted. There was no evidence provided by the facility to show the resident was provided with a Notice of Transfer.</p> <p>Interview with the Director of the facility on 07/22/10 at 3:00pm, revealed the facility did not provide a Notice of Transfer to residents requiring admission to a hospital for urgent medical needs. She stated she was not aware of the requirement to provide residents with a Notice of Transfer</p>	F 203		



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)	(X5) COMPLETION DATE
F 203	Continued From page 8 when they had to be admitted to a hospital from the facility.	F 203		
F 205 SS=D	<p>Interview with Resident #4 on 07/22/10 at 8:00am, revealed the resident did not remember receiving a Notice of Transfer prior to the hospital admission on 05/14/10.</p> <p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR</p> <p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide two (2) of eight (8) sampled residents (#4 and #8) with the facility's bedhold policy, which specified the duration of the bedhold under the State plan during which the resident was permitted to return</p>	F205	<p>The current bed hold policy has been revised to state that all residents will be provided a copy of the bed hold policy upon admission and any time they are absent from the facility. A copy of the revised policy will be given to all current residents as well as new admissions. All Nursing Facility nursing and aide staff will be educated by the Facility DON. The Facility DON or her designee will audit 100% of charts for patients who have been absent from the facility for three consecutive months. If 100% compliance is not obtained for a three month period, the audit period will be extended to six months. Monthly audit results will be reported to the CNO and the Quality Assurance Committee for</p>	8-27-10



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)	(X5) COMPLETION DATE
F 205	Continued From page 9 and resume residence in the facility, when they were transferred to the hospital from the facility. The findings include: Review of the facility's Bedhold Policy, undated, revealed the facility would hold a resident's bed for a maximum of fourteen (14) days and the bedhold policy would be provided to residents when admitted to the facility and again on transfer from the facility. Review of the clinical record for Resident #4 revealed the resident was admitted to the facility with Chronic Renal Failure. On 05/14/10, the resident required urgent medical treatment and was admitted to the hospital from the facility. There was no evidence the facility provided the resident with a copy of the Bedhold Policy. Interview with the Director of the Facility on 07/22/10 at 3:00pm, revealed the facility did not provide residents with a copy of the Bedhold Policy when the residents required transfer to a hospital for urgent medical needs. She stated she was not aware of the requirement.	F 205	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.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F225	Facility abuse policy will be revised that all employees will be screened for abuse prior to employment. The policy will require all CNA applicants to list each state in which they have worked as a CNA and the abuse registries in those states will be checked by the HR	8-27-10

