

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 01/03/2025
NAME OF PROVIDER OR SUPPLIER Breckinridge Memorial Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 Old Highway 60 Hardinsburg, KY 40143	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>51281</p> <p>Based on interviews and review of the facility's policies and procedures, it was determined the facility failed to protect and facilitate the residents' right to communicate with individuals and entities within and external to the facility, including the ability to send and receive mail, packages and other materials delivered to the facility for 3 of 18 sampled residents (Resident (R) 6, R8, and R14).</p> <p>The facility did not pick up, sort, and deliver mail to residents on weekend, more specifically on Saturday, to R6, R8, and R14, with the potential to affect 18 of 18 residents residing in the facility.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Resident Rights and Responsibilities last revised on 08/01/2001, on page 4, number 24 revealed, A resident shall be permitted to send and receive mail without hindrance, unless clinically contraindicated.</p> <p>In interview on 12/19/2024 at 9:50 AM with the Director of Nursing (DON); with the Administrator at 10:05 AM; and with the Assistant Director of Nursing (ADON) at 2:41 PM, they all stated the facility currently had no policy and/or procedure in place regarding residents' rights to send and/or receive mail on Saturdays.</p> <p>In interview with the Activities Director (AD) on 12/18/2024 at 1:30 PM, she stated residents did receive their mail on Monday through Friday in the facility. She further stated however, the Saturday mail was not picked up until Monday because the Business Office was not open on weekends. The AD additionally stated residents did not get their weekend mail until the following Monday.</p> <p>Review of the electronic medical record's (EMR's) for R6, R8, and R14 revealed all three residents had been assessed as having a Brief Interview for Mental Status (BIMS) score of 15, indicating they were all cognitively intact and interviewable.</p> <p>In interview with R6 and R8 on 12/18/2024 at 1:35 PM, both stated they were not aware they could send and/or receive mail on the weekend, specifically on Saturday, in the facility. Both R6 and R8 stated they did not receive any mail on Saturday, but said they were able to receive and send mail Monday through Friday.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In interview with R14 on 12/18/2024 at 1:40 PM, she stated she was not aware if she had ever received mail on the weekends or if she had ever received mail at all.</p> <p>In interview with the Supervisor of Patient Accounts on 12/19/2024 at 9:12 AM, she stated the Emergency Department (ED) staff brought the mail to the business office during the week where it was sorted then sent to each department. She said Saturday's mail was dropped off in the Business Office; however, since there were no staff working on the weekends, it did not get taken to the appropriate department until the following Monday.</p> <p>In interview with the [NAME] Clerk (WC) of the skilled nursing facility (SNF) unit on 12/19/2024 at 9:25 AM, she stated she went downstairs to the Business Office every morning, Monday through Friday, to pick up the SNF unit mail. She stated the mail she picked up each day was the mail from the previous day. The WC further stated the mail from Friday and Saturday was picked up on the following Monday.</p> <p>In interview with the Admitting Clerk in the ED on 12/19/2024 at 9:40 AM, she stated she was unaware of how the mail was picked up; however, said she was willing to help figure how it was. The ED Admitting Clerk phoned a staff person in the Business office who was unsure of how the mail was handled, but gave a different Business Office staff person's name. She phoned the second Business Office staff person who said she actually picked the mail up from the facility's mailbox and brought it to the Business Office, Monday through Friday.</p> <p>In interview on 12/19/2024 at 9:42 AM, the Business Office staff person, who picked up the mail, stated no one got the mail on Saturday from the mailbox. She said when she came back in to work on the following Monday, she picked up the mail from the mailbox, which included the Saturday and Monday mail. She further stated both days (Saturday's and Monday's) mail was taken to the Business Office on Monday.</p> <p>In interview with the Assistant Director of Nursing (ADON) on 12/19/2024 at 2:41 PM, she stated the Business Office brought the mail up each day, which had been placed in the mailbox that same day. She clarified the [NAME] Clerk was referring to employees' mail being received from the facility she picked up every day. The ADON stated the mailbox was located outside the ED. She said each day when the United States Parcel Service (USPS) delivered the mail, the Business Office staff person picked up the mail from the mailbox and dropped it off at the Business Office, where it was sorted then delivered to the appropriate department. The ADON reported no one picked up the mail from the mailbox on Saturdays because the Business Office was closed over the weekend. She stated the Business Office staff person picked up the Saturday and following Monday mail that following Monday. Per the ADON in interview, the residents received their mail the day it was delivered by the USPS, Monday through Friday. She said however, the mail that was dropped off on Saturday by the USPS was not delivered to the residents until the following Monday. The ADON stated she had never even thought about that issue, until it was brought up during the State Survey Agency (SSA) Recertification Survey. She reported residents did have a right to receive their Saturday mail on Saturday, even if the Business Office was closed for the weekend. The ADON further stated they were going to have to establish a policy or a process for residents to send and/or receive their mail on the weekend.</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In interview with the Director of Nursing (DON) on 12/19/2024 at 9:50 AM, she stated there was not currently a policy or process for picking up residents' mail on weekends. The DON stated someone from the Business Office picked up the mail, Monday through Friday. She reported however, since the Business Office was only open Monday through Friday 8:00 AM to 4:00 PM, she did not know who took care of the mail on Saturdays. The DON said the ED staff possibly were who picked up the mail from the mailbox through the week and dropped it off to the Business Office. The DON further stated she believed the residents had a right to send and/or receive their mail on the weekends, as well as through the week, regardless of the Business Office being closed over the weekend.</p> <p>In interview with the Administrator on 12/19/2024 at 10:05 AM, she stated there was no process or policy or procedure in place regarding picking up the mail on the weekend. The Administrator stated she had not ever thought of that being an issue. She further stated however, she agreed residents had a right to send and/or receive their mail on Saturday, as well as, through the week, regardless of the fact the Business Office was closed on the weekend.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50442</p> <p>Based on observation, interview, review of the facility's policy, the facility failed to have an effective system to label and store resident specific medications for 2 of 10 sampled Residents (Resident (R)10 and R12).</p> <p>On 12/17/2024 at 12:06 PM eight (8) vials of antibiotic were observed sitting in a plastic tub without a resident label and sixty (60) cups of valproic acid were observed in six (6) packs, also not labeled with a resident label. Both were stored in the medication room on the counter.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Medication Storage, reviewed 12/07/2022, revealed medications labeled for individual patients (residents) were stored separately from floor stock medications when not in the medication cart.</p> <p>Review of a written statement provided by the Pharmacy Director (PD) on 12/18/2024 at 1:25 PM, revealed he acknowledged medications brought to the Skilled Nursing Facility (SNF) should have been labeled and the medications found in the medication room on 12/17/2024 had been unlabeled, which was unacceptable. The PD noted the unlabeled medication situation had been corrected and it would not occur again. Per review, he did not disagree with the fact that unlabeled medications could increase the incidence of a medication (med) error. Continued review revealed the PD documented other instances would have to occur for a med error to occur, such as: a nurse giving the unlabeled medication without an eMAR (electronic Medication Administration Record) prompt; or if the medication was an intravenous (IV) medication like the antibiotics, and the nurse inserted an IV prior to administration. Further review revealed additionally, if the nurse omitted barcode scanning of the medication a med error could occur. In addition, the PD noted nurses would also have to omit the scanning of the resident's identification band; however, residents in the SNF did not have an identification band.</p> <p>1. Review of R10's electronic medical record (EMR) revealed the facility admitted the resident on 09/27/2022, with diagnoses of chronic kidney disease, anxiety, peripheral vascular disease, and fistula of the stomach and duodenum resulting in a cutaneous abscess of the abdominal wall.</p> <p>2. Review of R12's EMR revealed the facility admitted the resident on 03/27/2024, with diagnoses of Alzheimer's Disease, chronic kidney disease, hypertension, and seizures.</p> <p>Observation of the medication (med) room on 12/17/2024 at 1:28 PM, with Registered Nurse (RN) 3, revealed a plastic container that had IV eight vials of antibiotics in it. Per observation, there were no resident labels on any of the vials and none on the plastic container to identify who the antibiotics were for. Further observation of the med room revealed 6 flats (cardboard trays that had 10 cups of Valproic acid side by side in them with cellophane wrapped around them) which were also not labeled.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In interview, at the time of observation (12/17/2024 at 1:28 PM), RN 3 stated, when asked why the antibiotics and Valproic Acid were unlabeled and sitting on the counter in the med room, she stated R10 was the only individual getting intravenous (IV) antibiotics on the unit, so staff knew they belonged to R10. She stated there was not enough room in the med cart for all of R12's Valproic Acid, as six cups were used for her per day. The RN said, therefore staff stored the extra Valproic Acid in the med room and re-stocked the med cart with it as needed. RN 3 further stated she realized this practice could have caused possible med errors.</p> <p>In interview with the Pharmacy Director (PD) on 12/17/2024 at 3:18 PM, he stated 99.9% of all medications delivered to the SNF from the Pharmacy were in a baggy labeled with resident information. He said the resident label contained the order/prescription number, dosage times, directions for administration, name of the medication and dose, the resident's name, lot number, and dose expiration date. The PD reported sometimes IV medications might not have a resident label on it, if it was on the weekend and/or the medication was needed quickly. He said if that was the case he would drop the medication off unlabeled. The PD reported he had done that with the intention of putting labels on the medications when he came in the following Monday. (Interview was conducted on a Tuesday). He further stated he would immediately place the resident labels on the antibiotics.</p> <p>In continued interview on 12/17/2024 at 3:18 PM, the PD stated the Valproic Acid was stored on the counter in the med room with no resident label due to space constraints in the med cart; however, the medication should have been labeled. He stated he would also label each flat of 10 cups of Valproic Acid, not each individual cup. When asked by the State Survey Agency (SSA) Surveyor asked the PD what would happen if the plastic covering the individual cups was removed and thrown away, he said he hoped nursing staff would not throw away the plastic containing the label. He said however, he had never thought of that possibly occurring. The PD reported medications not labeled could go to an incorrect resident creating a med error. The SSA Surveyor asked the PD if a new resident admitted with orders for Valproic Acid and the medication was not labeled, he stated the medication could be given to the wrong resident. When asked how often he or his staff sent unlabeled medications to the SNF unit he stated that occurred about once per month.</p> <p>In interview with RN 2 on 12/18/2024 at 7:35 AM, she stated medications from the Pharmacy always came with a resident label on them. She stated if the medication did not have a resident label, she would take the medication back to the Pharmacy and have them place a label on it prior to administering the medication to the resident. The RN said, in reference to the cartons of Valproic Acid and antibiotics, the cartons of Valproic Acid should have a resident label on the carton and each vial of antibiotics should have a resident label on it. She further stated the purpose of the resident label on a medication was to prevent med errors.</p> <p>In interview with the Assistant Director of Nursing (ADON) on 12/19/2024 at 3:41 PM, she stated it was okay to give a medication from the pharmacy that did not have a resident label on it. She said that was because nursing staff should be scanning off the medication using bar code administration. The ADON further stated nursing staff should be double checking the order with the medication and performing the five rights of medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In interview with the Director of Nursing (DON) on 12/19/2024 at 5:12 PM, she stated she thought there should be a resident label on all the medications; however, if there was not a resident label, she would still administer the medication to a resident. She said the nursing staff scanned the bar code of the medication label as well as checked the medication against the resident's orders prior to administering the medication. The DON reported that process occurred for every medication administered, every time and it did not matter if the medication was from the medication cart, the medication room, or hand delivered from the Pharmacy.</p> <p>In interview with the Administrator on 12/19/2024 at 5:27 PM, she stated medications in the med storage room did not need to have a resident label on them to be administered. She stated a resident label was not the criteria that nurses used to identify the correct medication, dose, resident, etc. The Administrator stated all nurses should be performing the five rights of medication administration before giving any medication. She said the nurses also scanned the medication label's barcode to help with the five rights of medication administration. Further, the Administrator stated she did not think a medication error could happen just because the medication did not have a resident label on it.</p>		