

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

PRINTED: 04/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185465	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/23/2014
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 170 SYKES BOULEVARD MORGANFIELD, KY 42437		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 04/04/14 as alleged	{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 170 SYKES BOULEVARD MORGANFIELD, KY 40437		
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F 000	INITIAL COMMENTS	F 000	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.		
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 the facility's policy/procedure, it was determined the facility failed to serve food under sanitary conditions related to appropriate handwashing when handling food. Additionally, the facility failed to ensure appropriate maintenance of the ice machine. The total census in the facility was twenty-two (22) residents, who all receive meals from the facility. Findings include: 1. Review of the Hand-washing Guidelines policy, dated 02/01/02, revealed the purpose of the policy was to prevent the spread of bacteria that may cause food borne illnesses. Hands	F 371	483.35 FOOD PROCEDURE, STORE/PREPARE/SERVE - SANITARY 1. Handwashing Criteria 1 - Dietary staff were inserviced immediately after the observation was reported regarding the proper handwashing policy. Dietary staff will be trained annually on sanitation policies and procedures. Criteria 2 - The facility acknowledges all residents have the potential to be affected by the deficient practice. The Dietary manager and Administrator completed a walk through in the kitchen area to ensure no other areas of concern related to Sanitary food procedures. Dietary staff were inserviced regarding facility sanitary procedures in food preparation. Criteria 3 - The Dietary Manager will monitor staff during work hours to ensure staff are following facility handwashing policy guidelines. The Dietary Manager completed a check of all equipment to ensure proper cleaning had been performed to ensure sanitary conditions were present. Criteria 4 - The Dietary Manager has been performing routine monitoring of all staff in regards to handwashing procedures and policy. The Dietary Manager will continue random observation times to ensure all staff		

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(X6) DATE

Kathy Pogue

Administrator

4/9/2014

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F 371	<p>Continued From page 1</p> <p>should be washed every time an employee entered the kitchen.</p> <p>Observation of the tray line, on 03/18/14 at 12:00 PM, revealed the Dietary Aide left the kitchen wearing gloves, holding a tray with three prepared lunch plates. She came back to the kitchen with the empty tray and did not remove her gloves or wash her hands. She obtained two slices of bread with her hands from an open bag, placing one piece of bread on two different plates. She took the tray to the dining room with the two plates, wearing the same gloves. The Dietary Aide returned to the kitchen with the empty tray and did not remove the gloves or wash her hands. She put three more plates on the tray, placing one piece of bread (using her gloved hands) on each plate. She took the plates to the dining room and came back to the kitchen without washing her hands. She put one piece of bread on three more plates, wearing the same gloves. The Dietary Aide returned to the kitchen again, without washing her hands.</p> <p>Interview with the Dietary Manager, on 03/18/14 at 12:20 PM, revealed she expected staff to use hand sanitizer when coming back into the kitchen. She revealed the Dietary Aide should have used tongs for the bread, instead of her hands.</p> <p>Interview with the Administrator, on 03/20/14 at 12:00 PM, revealed she expects staff to follow the policy related to handwashing in the kitchen. Staff should wash their hands when entering the kitchen.</p> <p>2. Review of the Cleaning of Miscellaneous Equipment and Utensils policy, dated 05/01/03, revealed the ice machine should be cleaned at</p>	F 371	<p>continue to perform handwashing per policy guidelines. The Dietary Manager will report her observations during quaterly Quality Assurance Meetings times six months and then annually thereafter.</p> <p>Criteria 5 - Target Date</p> <p>2. Cleaning of Miscellaneous Equipmment</p> <p>Criteria 1 - When the observation was reported, Dietary staff emptied the ice machine, sanitized the interior and exterior of the machine. Dietary staff were inserviced regarding the proper cleaning policy and procedure for the ice machine and all dietary equipment.</p> <p>Criteria 2 - The facility acknowledges that all residents have the potential to be affected by the deficient practice due to utilization of one ice machine for all residents. The Dietary manager and Administrator completed a walk through in the kitchen area to ensure no other areas of concern related to Sanitary food procedures. Dietary staff were inserviced regarding facility sanitary procedures in food preparation.</p> <p>Criteria 3 - The Ice Machine has been added to the Dietary staff daily and monthly cleaning check lists. The Dietary Manager will monitor the cleaning schedule to ensure completion of task. The Environmental Services Director will add documentation to the Dietary cleaning log when completing quarterly sanitation of the ice machine. See attachments 1 (Daily cleaning) and 2 (Monthly cleaning).</p>	<p>3/31/2014 Per Adm 04/24/14</p>

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F 371	Continued From page 2 least quarterly. The procedure included to wash the machine, inside and out, including legs and handle. Rinse, sanitize, and dry. Observation of the ice machine, on 03/18/14 at 10:00 AM, revealed a thick collection of dark gray particles noted on the upper surface of the machine, visible when the cover was lifted. Interview with the Administrator, on 03/20/14 at 12:00 PM, revealed maintenance staff clean the ice machine quarterly; however, there is no documentation. She revealed dietary staff were expected to wipe down the machine, as part of their routine cleaning.	F 371	Criteria 3 Continued - The Dietary Manager completed a check of all equipment to ensure proper cleaning had been performed to ensure sanitary conditions were present. Criteria 4 - The Dietary Services Manager will review the cleaning check lists for completion as assigned. The Dietary Services Manager and/or designee will also perform routine spot-checks to ensure sanitation process has been completed. The Dietary Services Manager will complete a Dietary Department Audit quarterly. The Administrator and/or designee will complete an unannounced audit 1x/month for 3 months and unplanned thereafter to ensure compliance. Criteria 5 - Target Date:	4/4/2014	

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{K 000}	INITIAL COMMENTS Based upon the implementation of the acceptable POC, the facility was deemed to be in compliance, 05/04/14.	{K 000}		

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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: 2008.</p> <p>SURVEY UNDER: 2000 New.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (III).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2009, with 33 smoke detectors and 4 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 2008.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/19/14. Breckinridge Place was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Twenty-Two (22) beds with a census of Twenty-Two (22) 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	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy Poque</i>	TITLE Administrator	(X6) DATE 4/9/2014
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K 000	Continued From page 1 Fire).	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, fourteen (14) residents, staff and visitors. The facility is certified for Twenty-Two (22) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to ensure three (3) smoke barriers were sealed around pipes and wires to resist the passage of smoke.</p>	K 025	<p>K 025 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Criteria 1 - The deficient practice has been corrected by the Environmental Services Director as of 3/31/2014. The Environmental Services Director patched around all penetrations fully enclosing all smoke barriers.</p> <p>Criteria 2 - The facility acknowledges that all residents have the potential to be affected by the deficiency cited. The Environmental Service Manager completed a scan along the length of the fire wall to ensure all penetrations had been properly sealed.</p> <p>Criteria 3 - The Environmental Services Manager will do an inspection quarterly to ensure all smoke compartments are properly sealed. This will be reported during the quarterly Safety Committee Meeting.</p> <p>Criteria 4 - The Environmental Service Manager and/or Administrator will monitor all future installation projects to ensure contracted personnel properly seal any areas passing through the fire wall. The Environmental Service Manager will complete an inspection of the fire wall and report to the Quality Assurance team during quarterly meetings.</p> <p>Criteria 5 - Target Date</p>	3/31/2014

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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 03/19/14 between 1:05 PM and 2:18 PM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located at room #2, #9, and the long wall along the front of the facility penetrated by pipes and wires.</p> <p>Interview, on 03/19/14 between 1:05 PM and 2:18 PM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey.</p> <p>Interview, on 03/19/14 between 1:05 PM and 2:18 PM with the Maintenance Supervisor, revealed she has never checked on a smoke barrier in the facility. The facility has no policy on the smoke barriers and uses the Life Safety code to be in compliance. She was under the impression the barriers had been checked thoroughly by the maintenance supervisor.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be</p>	K 025			

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K 025	Continued From page 3 solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility	K 062	K 062 NFPA 101 LIFE SAFETY CODE STANDARD Sprinkler Riser Gauges Criteria 1 - Sprinkler Riser Gauges were replaced on 3/25/2014 by Koorsen Fire and Electric. Criteria 2 - The facility acknowledges all residents have the potential to be affected by the deficiency cited. Criteria 3 - The Environmental Services Director has noted the date of the new gauges and will review the gauge date upon annual inspections performed by contract company.		

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K 062	<p>Continued From page 4</p> <p>failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Two (22) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to ensure the gauges on the sprinkler riser had been replaced or recalibrated within the past five (5) years.</p> <p>The findings Include:</p> <p>Sprinkler record review, on 03/19/14 at 4:15 PM with the Maintenance Supervisor and Administrator, revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years.</p> <p>Interview, on 03/19/14 at 4:15 PM with the Maintenance Supervisor, revealed he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years.</p> <p>Interview, on 03/19/14 at 4:15 PM with the Administrator, revealed she was unaware of the time frame for replacing the gauges on the sprinkler riser. She stated she relies on her contractors to ensure the sprinkler system is maintained properly.</p> <p>Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could</p>	K 062	<p>Criteria 4 - The Administrator and/or designee will ensure the task of replacing dated gauges is completed timely to ensure a safe dwelling for all.</p> <p>Criteria 5 - Completion Date:</p> <p>2. Sprinkler Obstruction</p> <p>Criteria 1 - The Administrator contacted Ohio Valley Sprinkler Company regarding the obstructed sprinkler head. Upon review of the existing system it was determined additional sprinkler heads would be installed behind the wall obstructing the current sprinkler head.</p> <p>Criteria 2 - The facility recognizes 2 residents have the potential to be affected by the cited deficiency as there are only 2 private bath/shower rooms in the facility.</p> <p>Criteria 3 - An additional sprinkler head will be placed in the areas to ensure adequate coverage in the event of a fire.</p> <p>Criteria 4 - The added sprinkler heads will be included in the standard testing procedures of the facility.</p> <p>Criteria 5 - Target Date</p>	<p><i>03/26/14</i> <i>per Adm</i> <i>04</i></p> <p>3/25/2014</p> <p>5/4/2014</p>

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K 062	<p>Continued From page 5</p> <p>result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6</p>	K 062		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185465	(X2) MULTIPLE CONSTRUCTION A. BUILDING B1 - BRECKINRIDGE PLACE B. WING _____		(X3) DATE SURVEY COMPLETED 03/19/2014
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 170 SYKES BOULEVARD MORGANFIELD, KY 42437		
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K 062	Continued From page 6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 144 NFPA 101 LIFE SAFETY CODE STANDARD Criteria 1 - The Administrator contacted Evapar regarding the current agreement for testing. The additional load testing will be contacted at the time of the next scheduled visit. The Administrator will provide the specific testing requirements as provided in this document.		

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K 144	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Twenty-Two (22) beds with a census of Twenty-Two (22) on the day of the survey. The facility failed to ensure the generator was running at the proper load voltage monthly. The findings include: Generator record review, on 03/19/14 at 4:25 PM with the Maintenance Supervisor and Administrator, revealed the facility did not have record of an annual load bank test performed on the generator. Interview, on 03/19/14 at 4:25 PM with the Maintenance Supervisor, revealed he was unaware of the percentage the facility pulled from the generator and he wasn't aware of an annual generator load bank test being performed on the generator. Interview, on 03/19/14 at 4:25 PM with the Administrator, revealed she was unaware the testing was being performed on the generator. The bid from the generator company revealed the annual load bank test was listed on the bid for the generator.	K 144	Criteria 2 - The facility acknowledges that all residents have the potential to be affected by the deficiency cited. Criteria 3 - The Enviromental Services Director will monitor the testing performed by the contracted company to ensure compliance with regulatory requirements. The facility will require the contracted company to provide written reports pertaining to the completion of the required load testing. Criteria 4 - The Administrator will review all testing reports at the time testing is performed to ensure contracted company is performing all requirements to ensure compliance with regulations. Criteria 5 - Target Date 5/4/2014	

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K 144	Continued From page 8 Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		