

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

PRINTED: 06/06/2013  
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  05/22/2013
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  A recertification survey was conducted 05/19/13 through 05/22/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "F".	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update	F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) Criteria 1 – The facility immediately made contact with Resident #3's physician and received treatment orders. Family was notified of the changes. All was completed on 5/20/2013. All charge nurses will receive in-service training by the Director of Nursing and/or designee on the facility policy and procedure relating to "Physician/Legal Representative Notification and Physician Follow-up" as well as successfully completion of a physician notification competency test to ensure retention of information presented. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. On 5/22/2013 an audit was completed by the Director of Nursing and no other residents were found to be affected. Criteria 3 – The facility has developed and adapted a "Physician/Legal Representative Notification and Physician Follow-up" policy as of May 31, 2013. All current licensed personnel will be trained on the policy and any future new employees will be trained at orientation by the Director of Nursing and/or designee. Criteria 4 – The Director of Nursing and/or designee will ensure completion by the target date and will routinely review nurse log reports to ensure proper	

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

TITLE

(X6) DATE

*Just Ladd*

Administrator

7/16/2013

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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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the physician was notified regarding a change in condition for one resident (#3), in the selected sample of eight residents, related to a rash. Observation of a skin assessment for Resident #3, on 05/20/13, revealed a rash to his/her right buttocks, which had been there since 05/13/13 without physician notification.  Findings include:  A review of the facility's policy and procedure, Skin Assessments, undated, revealed "Assessment of the wound by a licensed nurse will be done when an area is initially identified and daily until healed."  A record review revealed the facility admitted Resident #3 on 05/03/10 with diagnoses to include Dementia-Alzheimer's with behavioral problems, Type II Diabetes Mellitus, Osteoarthritis, Morbid Obesity, and Cerebral Vascular Accident.  Observation of a skin assessment completed by Licensed Practical Nurse (LPN) #1 and with the assistance of two Certified Nurse Aides (CNA #1 and #2), on 05/20/13 at 10:15 AM, revealed Resident #3 had a red rash on his/her right	F 157	documentation of all resident concerns. The Director of Nursing and/or designee will complete a CQI tool titled "Notification of Change – N-23" monthly for six months and quarterly thereafter to ensure compliance. A tri-weekly spot audit will be performed by the Director of Nursing and/or designee to ensure that the physician notification policy is being followed. Criteria 5 – Target Date:	06/28/2012	

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F 157	Continued From page 2 buttocks. Interview with CNA #1 revealed the red rash had been there since 05/13/13, and was reported to the charge nurse on duty, Registered Nurse (RN) #1.  An interview with RN #1, on 05/20/13 at 3:20 PM, revealed she recalled the CNAs showing Resident #3's rash to her, and she told the CNAs to continue to use preventative cream on the area, which was used after incontinent care. Additionally, she stated she did not notify the physician for a new order for different treatment because the area just appeared red from incontinence. She stated she passed the information to the oncoming shift in report, for the CNAs to continue to use the cream. She verified she should have documented the treatment.  An interview with the Director of Nursing (DON), on 05/20/13 at 3:35 PM, revealed she expected RN #1 to contact the physician and get a new treatment, and to document in the nurses' notes regarding the area.	F 157			
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	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  Criteria 1 - All undated items were immediately removed from the dietary department and disposed of appropriately. Staff was re-trained on appropriate temperatures for serving by the Dietary Services Manager. Criteria 2 - The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 - To correct the issue with proper labeling and dating, the Dietary Services Manager initiated "timeline and task checklist" that will require staff on-duty for all shifts to complete certain tasks as assigned. To correct the issue with food maintaining proper temperatures, the		

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F 371	<p>Continued From page 3</p> <p>by: Based on observation and interview, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observation of the kitchen, on 05/19/13, revealed several items in the refrigerator and freezer with no dates, as well as outdated food items. Additionally, on 05/20/13, during an observation of the tray line service, baked beans were served at 120 degrees Fahrenheit (F) and pureed pork at 114 degrees F after leaving the tray line.</p> <p>A review of the facility's census and condition, dated 05/19/13, revealed there were 22 residents in the facility with two of those residents being tube feeders and not utilizing the kitchen facilities.</p> <p>Findings include:</p> <p>1. An observation of the refrigerator and freezer areas, on 05/19/13 at 3:10 PM, revealed 13 undated bottles of condiments, no dates on hamburger patties, and a container of Bar-B-Que dated 04/04/13. Additionally, there were two pans of baked beans, a pan with several layers of bacon, one bag of frozen mixed vegetables, and one of Brussels sprouts, all without dates.</p> <p>An interview with the Dietary Manager, on 05/19/13 at 3:30 PM, revealed the policy of the facility was that food items and salads were good for seven days from the date marked as opened. She stated the food items should be dated, and the refrigerators were suppose to be checked on Sunday evenings, before the staff left and "everything gets pulled."</p>	F 371	<p>facility has purchased deeper serving line pans that will ensure that the prepared food is kept at the appropriate temperatures during serving. All dietary staff received in-service training on 5/22/2013 by the Dietary Services Manager.</p> <p>Criteria 4 – The Dietary Services Manager and/or designee will ensure completion by the target date and will ensure timeline and task checklists are completed daily. The Dietary Services Manager and/or designee will also perform routine spot-checks at a minimum of 3x/week to ensure that all items are properly dated and stored and that food temperatures are being maintained at appropriate levels. The Dietary Services Manager will complete a Dietary Department Audit 1x/month for 6 months and quarterly thereafter. The Administrator and/or designee will complete an unannounced audit 1x/month for 3 months and unplanned thereafter.</p> <p>Criteria 5 – Target Date:</p>	05/24/2013	

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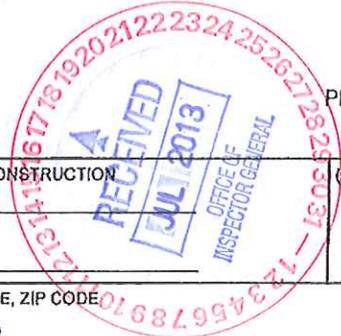
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F 371	Continued From page 4 2. An observation of the kitchen, on 05/20/13 at 11:30 AM, revealed baked beans left the tray line at 120 degrees F and pureed pork at 114 degrees F.  An interview with the Dietary Aide, on 05/20/13 at 11:36 AM, revealed she thought 120 degrees F on the baked beans was acceptable, because they were served from cans; however, she was unaware the pureed pork was 114 degrees F.  An interview with the Dietary Manager, on 05/20/13 at 11:45 AM, revealed food temperatures should be at least 135 degrees F, prior to leaving the tray line.	F 371			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency call lights were equipped with pull cords for four residents' rest rooms #3, #6, #11, and #17. The facility census was 22.  Findings Include:  Observations during initial tour, on 05/19/13 from 2:15 PM until 2:40 PM, revealed four residents' rest rooms (#3, #6, #11, and #17) with missing or broken pull cords on the emergency call lights.	F 463	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILETS/BATH  Criteria 1 - The missing or broken pull cords on the emergency call lights were all replaced on 5/21/2013 by the Environmental Services Director. The Environmental Services Director then proceeded to audit the remaining eighteen rooms to ensure that all pull cords functioned appropriately on 5/21/2013. Criteria 2 - The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 - The facility has added routine checks of the nurse call system (including the restroom facilities) to the preventative maintenance log and these will be checked weekly. All staff will be in-serviced on 6/21/2013 during a facility-wide in-service on how to enter a maintenance work order and the		

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F 463	Continued From page 5  An interview with the Maintenance Director, on 05/21/13 at 2:05 PM, revealed he was not aware of any problems with the call light cords and had not received a work order to have them fixed. He stated there was no set routine for resident room checks to ensure the environment was safe, intact, and equipment was functioning properly. Upon further evaluation, the Maintenance Director found the cording to be "dry rotted: and in need of replacement.	F 463	Importance of entering those work orders by the Administrator and/or designee. <b>Criteria 4</b> – The Administrator and/or designee will review the preventative maintenance log monthly to ensure proper checks are being completed. The CQI tool titled "General Environment ES-1" has adapted checks to the nursing call system in all rooms including restrooms. <b>Criteria 5</b> – Target Date:	06/21/2013	

Office of Inspector General



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N 000	INITIAL COMMENTS  A relicensure survey was conducted 05/19/13 through 05/22/13 to determine the facility's compliance with State requirements. The facility failed to meet the minimum requirements for relicensure with deficiencies cited.	N 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.	
N 019	902 KAR 20:300-3(2)(i)1.c. Section 3. Resident Rights  (2) Notice of rights and services. (i) Notification of changes. 1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is: c. A need to alter treatment significantly; or  This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the physician was notified regarding a change in condition for one resident (#3), in the selected sample of eight residents, related to a rash. Observation of a skin assessment for Resident #3, on 05/20/13, revealed a rash to his/her right buttocks, which had been there since 05/13/13 without physician notification.  Findings include:  A review of the facility's policy and procedure, Skin Assessments, undated, revealed "Assessment of the wound by a licensed nurse will be done when an area is initially identified and daily until healed."	N 019	902 KAR 20:300-3(2)(i)1.c. Section 3. Resident Rights Criteria 1 – The facility immediately made contact with Resident #3's physician and received treatment orders. Family was notified of the changes. All was completed on 5/20/2013. All charge nurses will receive in-service training by the Director of Nursing and/or designee on the facility policy and procedure relating to "Physician/Legal Representative Notification and Physician Follow-up" as well as successfully completion of a physician notification competency test to ensure retention of information presented. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. On 5/32/2013 an audit was completed by the Director of Nursing and no other residents were found to be affected. Criteria 3 – The facility has developed and adapted a "Physician/Legal Representative Notification and Physician Follow-up" policy as of May 31, 2013. All current licensed personnel will be trained on the policy and any future new employees will be trained at orientation by the Director of Nursing and/or designee. Criteria 4 – The Director of Nursing and/or designee will ensure completion by the target date and will routinely review nurse log reports to ensure proper	

*Just Ladd*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
Administrator

(X6) DATE  
7/16/2013

Office of Inspector General

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N 019	Continued From page 1  A record review revealed the facility admitted Resident #3 on 05/03/10 with diagnoses to include Dementia-Alzheimer's with behavioral problems, Type II Diabetes Mellitus, Osteoarthritis, Morbid Obesity, and Cerebral Vascular Accident.  Observation of a skin assessment completed by Licensed Practical Nurse (LPN) #1 and with the assistance of two Certified Nurse Aides (CNA #1 and #2), on 05/20/13 at 10:15 AM, revealed Resident #3 had a red rash on his/her right buttocks. Interview with CNA #1 revealed the red rash had been there since 05/13/13, and was reported to the charge nurse on duty, Registered Nurse (RN) #1.  An interview with RN #1, on 05/20/13 at 3:20 PM, revealed she recalled the CNAs showing Resident #3's rash to her, and she told the CNAs to continue to use preventative cream on the area, which was used after incontinent care. Additionally, she stated she did not notify the physician for a new order for different treatment because the area just appeared red from incontinence. She stated she passed the information to the oncoming shift in report, for the CNAs to continue to use the cream. She verified she should have documented the treatment.  An interview with the Director of Nursing (DON), on 05/20/13 at 3:35 PM, revealed she expected RN #1 to contact the physician and get a new treatment, and to document in the nurses' notes regarding the area.	N 019	documentation of all resident concerns. The Director of Nursing and/or designee will complete a CQI tool titled "Notification of Change - N-23" monthly for six months and quarterly thereafter to ensure compliance. A tri-weekly spot audit will be performed by the Director of Nursing and/or designee to ensure that the physician notification policy is being followed. Criteria 5 --Target Date	06/28/2012
N 185	902 KAR 20:300-7(2)(e) Section 7. Resident Assessment  (2) Comprehensive assessments.	N 185		

Office of Inspector General

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N 185	Continued From page 2  (e) Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under subsection (4) of this section. This requirement is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency call lights were equipped with pull cords for two residents' rest rooms #11 and #17. The facility census was 22.  Findings include:  Observations during initial tour, on 05/19/13 from 2:15 PM until 2:40 PM, revealed two residents' rest rooms (#11 and #17) with missing or broken pull cords on the emergency call lights.  An interview with the Maintenance Director, on 05/21/13 at 2:05 PM, revealed he was not aware of any problems with the call light cords and had not received a work order to have them fixed. He stated there was no set routine for resident room checks to ensure the environment was safe, intact, and equipment was functioning properly. Upon further evaluation, the Maintenance Director found the cording to be "dry rotted" and in need of replacement.	N 185	902 KAR 20:300-7(2)(e) Section 7. Resident Assessment  Criteria 1 – The missing or broken pull cords on the emergency call lights were all replaced on 5/21/2013 by the Environmental Services Director. The Environmental Services Director then proceeded to audit the remaining eighteen rooms to ensure that all pull cords functioned appropriately on 5/21/2013. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – The facility has added routine checks of the nurse call system (including the restroom facilities) to the preventative maintenance log and these will be checked weekly. All staff will be in-service on 6/21/2013 during a facility-wide in-service on how to enter a maintenance work order and the importance of entering those work orders by the Administrator and/or designee. Criteria 4 – The Administrator and/or designee will review the preventative maintenance log monthly to ensure proper checks are being completed. The CQI tool titled "General Environment ES-1" has adapted checks to the nursing call system in all rooms including restrooms. Criteria 5 – Target Date:	06/21/2013
N 283	902 KAR 20:300-10(8)(b) Section 10. Dietary Services  (8) Sanitary conditions. The facility shall: (b) Store, prepare, distribute, and serve food under sanitary conditions; and  This requirement is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store, prepare,	N 283		

Office of Inspector General

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N 283	<p>Continued From page 3</p> <p>distribute and serve food under sanitary conditions. Observation of the kitchen, on 05/19/13, revealed several items in the refrigerator and freezer with no dates, as well as outdated food items. Additionally, on 05/20/13, during an observation of the tray line service, baked beans were served at 120 degrees Fahrenheit (F) and pureed pork at 114 degrees F after leaving the tray line.</p> <p>A review of the facility's census and condition, dated 05/19/13, revealed there were 22 residents in the facility with two of those residents being tube feeders and not utilizing the kitchen facilities.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>An observation of the refrigerator and freezer areas, on 05/19/13 at 3:10 PM, revealed 13 undated bottles of condiments, no dates on hamburger patties, and a container of Bar-B-Que dated 04/04/13. Additionally, there were two pans of baked beans, a pan with several layers of bacon, one bag of frozen mixed vegetables, and one of Brussels sprouts, all without dates.</li> <li>An interview with the Dietary Manager, on 05/19/13 at 3:30 PM, revealed the policy of the facility was that food items and salads were good for seven days from the date marked as opened. She stated the food items should be dated, and the refrigerators were suppose to be checked on Sunday evenings, before the staff left and "everything gets pulled."</li> <li>An observation of the kitchen, on 05/20/13 at 11:30 AM, revealed baked beans left the tray line at 120 degrees F and pureed pork at 114 degrees F.</li> </ol>	N 283	<p><del>902 KAR 20:300-10(6)(b)</del> Section 10. Dietary Services</p> <p><b>Criteria 1</b> – All undated items were immediately removed from the dietary department and disposed of appropriately. Staff was re-trained on appropriate temperatures for serving by the Dietary Services Manager.</p> <p><b>Criteria 2</b> – The facility acknowledges that all residents have the potential to be affected by this deficient practice.</p> <p><b>Criteria 3</b> – To correct the issue with proper labeling and dating, the Dietary Services Manager initiated "timeline and task checklist" that will require staff on-duty for all shifts to complete certain tasks as assigned. To correct the issue with food maintaining proper temperatures, the facility has purchased deeper serving line pans that will ensure that the prepared food is kept at the appropriate temperatures during serving. All dietary staff received in-service training on 5/22/2013 by the Dietary Services Manager.</p> <p><b>Criteria 4</b> – The Dietary Services Manager and/or designee will ensure completion by the target date and will ensure timeline and task checklists are completed daily. The Dietary Services Manager and/or designee will also perform routine spot-checks at a minimum of 3x/week to ensure that all items are properly dated and stored and that food temperatures are being maintained at appropriate levels. The Dietary Services Manager will complete a Dietary Department Audit 1x/month for 6 months and quarterly thereafter. The Administrator and/or designee will complete an unannounced audit 1x/month for 3 months and unplanned thereafter.</p>	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  101101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  05/22/2013
NAME OF PROVIDER OR SUPPLIER  BRECKINRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 170 SYKES BOULEVARD MORGANFIELD, KY 42437		
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N 283	Continued From page 4  An interview with the Dietary Aide, on 05/20/13 at 11:36 AM, revealed she thought 120 degrees F on the baked beans was acceptable, because they were served from cans; however, she was unaware the pureed pork was 114 degrees F.  An interview with the Dietary Manager, on 05/20/13 at 11:45 AM, revealed food temperatures should be at least 135 degrees F, prior to leaving the tray line.	N 283	Criteria 5 – Target Date:	05/24/2013	

## PHYSICIAN/LEGAL REPRESENTATIVE NOTIFICATION AND PHYSICIAN FOLLOW UP

### POLICY:

It is the policy of Breckinridge Place Retirement Community to inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family.

### Procedure:

Notification will occur immediately when:

- There is an accident involving the resident which results in injury and has the potential for requiring physician intervention.
- There is a significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental or psychosocial status), life threatening conditions or clinical complications.
- There is a need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment).
- There is a decision to transfer or discharge the resident from the facility specified

Follow up on obtaining of physician response:

Attempt to contact the primary physician times three and if unsuccessful contact the medical director should be contacted to obtain intervention.

### PROCEDURE:

1. If no response from physician following initial contact and intervention is required (if emergency, send to nearest emergency department) within 2 hours, a second attempt should be made to contact the physician. If no response within 1 hour of second attempt, attempt x three. If the physician still has not responded with orders the medical director is to be contacted when an intervention is required.
2. Labs: If critical level labs follow the above procedure. All other lab results physician notification/response must be done within 24-hours.

3. For urine samples or non-blood samples, unless the physician orders it STAT they will be picked up on our next lab draw day. The physician will be contacted and will have 24 hours to respond x 3 contacts. The medical director will then be called.



7. A SKIN RASH HAS APPEARED ON A RESIDENT AND IT APPEARS TO BE FROM INCONTINENCE. IT IS OK TO APPLY BARRIER CREAM, NOT CHART, AND NOT CONTACT MD. **TRUE OR FALSE**
  
8. IT IS 0200 AND A RESIDENT IS DECLINING IN CONDITION. THE RESIDENTS PRIMARY CARE PHYSICIAN'S OFFICE IS CLOSED. IT IS OK TO WAIT UNTIL MORNING AND SEND A FAX FOR THE TIME BEING. **TRUE OR FALSE**
  
9. A RESIDENT HAS FALLEN AND HAS NO APPARENT INJURY AND NO COMPLAINTS OF PAIN. IT IS OK TO SEND A FAX NOTIFYING THE PHYSICIAN. **TRUE OR FALSE**
  
10. A RESIDENT HAS FALLEN AND HAS A BRUISE TO HER FOREHEAD. SHE IS COMPLAINING OF A HEADACHE AND PAIN RATED A 3/10. HER FAMILY IS AWARE AND DOES NOT WANT TO SEND HER TO THE ER. HER VITAL SIGNS AND NEURO CHECKS ARE WNL. IT IS OK TO SEND A FAX NOTIFYING THE MD. **TRUE OR FALSE**

Please turn into Director of Nursing when complete.



### Morning Cook Timeline and Task Checklist

Please initial as task are complete. Turn in to Supervisor at end of shift.

Cook/Date: \_\_\_\_\_

TIME	JOB DUTY/TASK
5:30am _____	After clocking in, come to the kitchen and put on you bagged eggs (if needed) for breakfast. Fill sanitation buckets with sanitizing solution from 3 compartment sink. Place them on the stations. Sanitize work surfaces before beginning. Turn on the dish machine and let it fill. Set up dish area with the silverware soak. Wash any dishes returned from the night shift. Look at menu and items ready to cook breakfast.
5:45am _____	Check spreadsheets and menu. Put breakfast food in oven, on stove or whatever needs to be done to cook breakfast. Check and record temps of equipment. Turn on steam-table and toaster if needed. Turn on oven to low/200 to heat the pellets and the plates. Put enough ceramic monkey bowls in oven to hold fried eggs. Turn on hood lights and exhaust fan.
6:00am _____	Call ext. 309 and check census Organize, cut and highlight tray cards for breakfast. Fill trays with coffee cups and organize top of food serving carts.
6:15am _____	Puree and ground items should be prepared at this time. Assure all ground meats have gravy, special request items and supplements are gathered at this time. *Remember- Oatmeal must be puree for related textures. At this time you should have all proper portion scoops out and temps of food taken and recorded.
6:25am _____	Get out drinks and get set-up to assemble breakfast trays. Don't forget to get your milk, water and juices. Cereal is on shelf above serving line.
6:30am _____	Start the tray services process, and deliver the carts to their destination. Assisted living should be coming around this time to pick up their breakfast items as well.
7:00am _____	Start breaking down the steam-table, at this time you can puree any eggs you had left over to use the next day for breakfast. Make sure to label and date items appropriately. Pull dinner rolls to rise and put any long cooking foods in for lunch at this time. Re-Stock the shakes, yogurt, butter and items in the refrigerated cabinet by steamtable. Stay in the kitchen due to the chance someone may need an item for a resident.
7:20am	15 minute break
7:35am- 9:00am _____	Wash dishes from carts returned from delivery, put dishes away. Record dish machine temps, sanitizer temps. Roll silverware. Sanitize work areas.

### Prep Timeline and Task Checklist

Please initial as task are complete. Turn in to Supervisor at end of shift

Cook /Date: \_\_\_\_\_

TIME	JOB DUTY/TASK
10:30-11:00 _____	Resident Interviews : Make sure you take your always available menu with you
11:00-11:10 _____	Look over menu to make sure you have all of your ingredients needed to prep
11:10 -11:30 _____	Prep drinks for lunch. Gather condiments, coffee, ice cream and all other items needed to serve lunch. Assist the cook to dining room, set up
11:30-11:45 _____	Set up trays and assemble. And serve cart to hall
11:45-12:00 _____	Assemble trays to serve in dining room. Serve desert after the meal has been served.
12:00-2:15 _____	Begin prepping for the meal for the next day. Deliver 2 o'clock snack Clean area: make sure you sweep, empty trash, and wash your dishes
2:15-2:30	15 minute break
4:10 -4:30 _____	Prep Drinks. Finish any other task before serving. Sanitize work areas
4:30 -4:45 _____	Hall Cart is ready for floor
4:45 -5:00pm _____	Serve dinner in main dining room. If all task are completed you should be ready to clock out.

Times may vary day by day but your tasks remain the same on a daily basis.

By signing you are stating that you have completed each task to the best of your ability and will be held accountable for incomplete processes. Disciplinary actions could result in items left without being recognized.

### Afternoon Cook Timeline and Task Checklist

Please initial as tasks are complete. Turn in to Supervisor at end of shift.

Cook/Date: \_\_\_\_\_

Time	Job Duty/Task
1:30pm	Clock In/Report to kitchen ready to work Meet with AM COOK Discuss residents OOF/meal status, counts, discharges
1:50-2:10	Check temps of equipment/ Assure temps are with-in accepted range Turn on necessary equipment/ Equipment must be in good working order Change sanitizer water/Test sanitizer water and record results/Sanitize work surfaces
2:10- 2:25	Check menu, spreadsheets and special request items and organize yourself Start long cook items/ pull dinner rolls at this time if needed for meal Make salads and sandwiches needed for SK and AL
2:25-3:00	Check cleaning schedule and complete those task at this time(steam table, walls, ovens, steamer, things that take a little more time to complete)
3:00-3:10	Cut, highlight and organize tray cards.
3:15-3:30	15 Minute Break
3:30-4:15	Sanitize work surfaces Cook meals items for dinner Grounds and puree diets(gravy and/or sauce for all meats) Set up dining room Dish up desserts Set up tray line and ready to assemble trays for hall
4:35-4:45	Take all food temps assure food is appropriate temp if not reheat Prepare and assemble tray for the hall service And deliver to nursing unit, be sure to notify staff of cart arrival
4:45-5:00	Assemble plates for dining room service
5:00-7:00	Deliver desserts to dining room Tear down steam table and save appropriate items, package, label and date. Wipe down cooking equipment (stove, oven, steamer, flat top, deep fryer) Wipe and sanitize work surfaces. Wash pots and pans Wash dishes, wipe down tray delivery carts (inside and out) Record dish machine temps Sweep and mop floors (while waiting for AL to come wash their dishes and finish) Empty dish machine and clean up dish area. Sweep and mop. Wipe down stainless dish line. Assure three compartment sink is clean and wiped down. Put all dishes away Take out all trash and make sure cans are clean and have new liners in place. Deliver PM snacks Clock out for the day

Times may vary day by day but your tasks remain the same on a daily basis.

By signing you are

stating you have completed each task to the best of your ability and will be held accountable for incomplete processes. Disciplinary actions could result in items left without being recognized.

**Breckinridge Place Retirement Community**

**Preventative Maintenance Checklist**

Month: \_\_\_\_\_

**Weekly Maintenance Log**

Emergency Lighting: Battery Packs must be tested to ensure proper functioning.

1x per year, test battery for 90 minutes – Last Completed: \_\_\_\_\_ Due: \_\_\_\_\_

Date			
Initials			

Emergency Lighting (Transfer Switch & Generator): tested to ensure proper functioning.

Date			
Initials			

Nurse Call System: Call lights in rooms, restrooms and at nurse's stations all functioning properly.

Date			
Initials			

Room Safety Checks: Check all resident rooms to ensure that each room is free from any potential dangers (i.e.: extension cords, multiple plug, etc.).

Date					
Initials					

Laundry Dyer Cleaning: Clean burners and rear of dryers weekly.

Date					
Initials					

Electrical Powered Smoke Detectors: Make sure they are operating properly.

Date					
Initials					

Roller Latch Inspection: Proper operation. (Check all sliding doors in Assisted Living.)

Date					
Initials					

Wheelchair Scale: Make sure there are no loose connections or frayed wires. Check calibration with two 5lbs weights to ensure scale is accurate.

Date					
Initials					

Door Alarms: Make sure all door alarms are functioning properly. Replace batters 1x/month & document replacement date.

Date					
Initials					

### Monthly Maintenance Logs

Laundry Washer Cleaning: Grease washers and clean screens

Date	
Initials	

Clean washer trap every month.

Date	
Initials	

Emergency Outlet Testing: Operating properly and grounded.

Date	
Room Number	
Initials	

Mechanical Lifts: All mechanical lifts are functioning properly. No frayed wires and batteries are charged.

Date	
Initials	

Electrical Panel Box: Locked and not blocked

Date	
Initials	

Eye Wash Stations: Caps are on and stations are operating properly.

Date	
Initials	

Fire Extinguishers: Check seals and gadgets

Date	
Initials	

Fire Door Inspection: Hold open devices work properly and doors close properly. No gaps in doors.

Date	
Initials	

Fire Drills: Must be held on one shift per month. Follow the Fire Drill schedule.

Date	
Time	
Initials	

Handrails: Make sure all hand rails are secure to the wall.

Date	
Initials	

Wheelchairs: All wheelchairs are clean and functioning properly.

Date	
Initials	

Kitchen Hood: Clean Kitchen hood.

Date	
Initials	

Air Conditioner Vents: Clean air conditioner vents in kitchen area.

Date	
Initials	

Sprinklers: Clean sprinkler heads. Make sure sprinkler heads are secure to the ceiling.

Date	
Initials	

HVAC filters: Clean washable filters in resident's rooms. Change air conditioner filters.

Date	
Initials	

Air Conditioner Compressors: Clean compressors monthly. (Use coil cleaner)

Date	
Initials	

Shuttle Inspection: To ensure that all electrical components are working properly (brakes, lights, turn signals, seat belts, tire pressure, heating and air conditioner. Make sure fluids are changed regularly. Check belts and hoses for wear and cracks.

Date	
Initials	

Wheelchair lift: Grease lift shafts. Make sure there are no loose damaged parts. Check all electrical connections (no frayed wires) Inspect lift platform for weld breaks and stress cracks. Make sure lift is in good working condition.

Date	
Initials	

Beauty Shop: Ensure that the blow dryer vent is cleaned and dust and dirt free. Clean the filter if possible.

Date	
Initials	

Automatic release on 9-16 hall: test automatic closure on door.

Date	
Initials	

Describe any other preventive maintenance completed this month:

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Describe the areas where touch up painting was completed this month:

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Describe in detail any rooms or items that were sprayed with flame retardant:

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Maintenance Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Administrator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

PRINTED: 06/06/2013  
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 B1 - BRECKINRIDGE PLACE  B. WING _____	(X3) DATE SURVEY COMPLETED  05/22/2013
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)	(X6) COMPLETION DATE
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 2009.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/22/13. 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	<p>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.</p> <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 5/28/2013. The Environmental Services Director patched around all penetrations fully enclosing all smoke barriers.</p> <p>Criteria 2 – No specific resident was impacted by the cited deficiency.</p> <p>Criteria 3 – The Environmental Services Director will do an inspection quarterly to ensure all smoke compartments are properly sealed. This will be a part of the Safety Committee Meeting that is held quarterly.</p> <p>Criteria 4 - The Administrator and/or designee will ensure that the tasks are completed to ensure a safe dwelling for all.</p> <p>Criteria 5 – Target Date</p>	05/28/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Just Ladd* TITLE: Administrator (X6) DATE: 6/14/13

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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K 000	Continued From page 1 Fire).	K 000		
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFFA 101 LIFE SAFETY CODE STANDARD 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  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 NFFA 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 four (4) smoke barriers were sealed around pipes and wires to resist the passage of smoke.	K 025		

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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observations, on 05/22/13 at 12:52 PM with the Maintenance Supervisor and the Administrator, revealed the smoke partitions, extending above the ceiling located in the attic at rooms # 17, 9, and 1 were penetrated by pipes and wires. Further observation revealed the wall next to the maintenance office was penetrated by a wire.</p> <p>Interview, on 05/22/13 at 12:52 PM with the Maintenance Supervisor and the Administrator, revealed they were unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. They were unaware the barriers were to be maintained in the attic as well as the area above the drop ceilings in the corridors.</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"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining</li> </ol>	K 025		

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K 025	Continued From page 3 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 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056	<b>K 056 LIFE SAFETY CODE STANDARD</b> <b>Criteria 1</b> – The facility has ordered new light fixtures that will not be an obstruction to the sprinkler fixtures. These fixtures were ordered on 6/11/2013. The spec sheet for the light fixtures states that the fixture is 7.31" wide and 1.75" in height. <b>Criteria 2</b> – No specific resident was impacted by the cited deficiency. <b>Criteria 3</b> – The action taken in criteria 1 will correct the problem and it will not recur. The lights will be installed upon their arrival from the vendor. <b>Criteria 4</b> – The Administrator and/or Maintenance Director will oversee this project until completion. <b>Criteria 5</b> – Target Date	07/05/2013	

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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  05/22/2013
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	
K 056	Continued From page 4  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect three (3) 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 sprinkler heads were not blocked by light fixtures in the resident rooms and two (2) mechanical rooms.  The findings include:  Observations, on 05/22/13 at 12:48 PM with the Maintenance Supervisor and the Administrator, revealed the sprinkler heads located in the resident rooms on halls 1, 2, and 3 were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the mechanical rooms and housekeeping closets on each hall.  Interview, on 05/22/13 at 12:48 PM with the Maintenance Supervisor and the Administrator, revealed they were unaware that the light fixtures could block the spray pattern of the sprinkler head.  Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in	K 056			

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

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K 056	<p>Continued From page 5</p> <p>accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.6.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th style="text-align: left;">Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
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