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

PRINTED: 12/09/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185465	B. WING _	B. WING		12/07/2020	
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 PREFI TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 000	was initiated and confacility was found to be CFR 483.80 infection implemented the Cen Medicaid Services (C Disease Control and recommended practic COVID-19. Total cens	d Infection Control Survey cluded on 12/07/2020. The period in compliance with 42 control regulations and has paters for Medicare & EMS) and Centers for Prevention (CDC) coes to prepare for		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.

Facility ID: 101101

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185465	B. WING _	B. WING		12/07/2020	
NAME OF PROVIDER OR SUPPLIER  BRECKINRIDGE PLACE			•	STREET ADDRESS, CITY, STATE, ZIF 170 SYKES BOULEVARD MORGANFIELD, KY 42437	STREET ADDRESS, CITY, STATE, ZIP CODE 170 SYKES BOULEVARD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE A) CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Survey was initiated of concluded on 12/07/2	d Emergency Preparedness on 12/07/2020 and 2020. The facility was found with 42 CFR 483.73 related	E	DEFICIE	NCY)		
L ABORATORY I	 	SUPPLIER REPRESENTATIVE'S SIGNATUI	RF	TITLE		0	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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Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE	(3) DATE SURVEY COMPLETED		
			A. BUILDING:					
	<b>101101</b> B. W		B. WING		12/07/2020			
NAME OF PROVI	IDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE				
BRECKINRIDGE PLACE  MORGANFIELD, KY 42437								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL				(X5) COMPLETE DATE		
N 000 Ini	itial Comments		N 000					
A 0 wa fac	COVID-19 Focused as initiated and cond	Infection Control Survey cluded on 12/07/2020. The e in compliance pursuant to	N 000					

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

TITLE (X6) DATE