

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

PRINTED: 06/07/2011  
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  05/20/2011
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  An annual survey was conducted, on 05/18/11 through 05/20/11, to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S 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 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of the facility policy, it was determined the facility failed to ensure residents received food prepared in a manner which retained food quality, taste and appearance. Food was placed on plates and set on trays on the counter until all trays were prepared before being loaded into the covered carts for distribution to the residents. The delay in service, allowed the food to cool too quickly, necessitating the food be microwaved several times, prior to serving the noon meal, on 05/18/11. In addition, residents complained that vegetables and fruits were served, which contained several chunks of ice and the food was not properly thawed and cooked. A review of the Census and Condition Report, dated 05/18/11, revealed the facility census was 16, with 15 of the 16 residents served food from the kitchen.	F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Criteria 1 – The deficient practice was corrected by providing documented in-service education regarding "Taking Food Temps – Why & How" to dietary staff members on 5-25-11 by the Dietary Supervisor (see attached). Additional in-service education regarding "Tray Line Efficiency & Accuracy" to dietary staff members was provided on 6-11-11 by the Registered Dietician and on 6-14-11 by the Dietary Supervisor (see attached). Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. A Continuous Quality Improvement (CQI) audit (attached; D-6) has been implemented and will be completed monthly x6, then quarterly by the Dietary Supervisor. Criteria 3 – The specific measure(s) that will be put in place to ensure the deficient practice doesn't reoccur includes: (1) the Dietary Supervisor will complete a Dietary Department Audit (CQI D-8, see attached) monthly and the Registered Dietician will complete the Dietary Department Audit quarterly to monitor compliance. (2) The CQI audit titled "Dining Service" (CQI D-6, see attached) will be completed by the		

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

*Just said*

TITLE

Administrator

(X6) DATE

6-17-11

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 364	<p>Continued From page 1</p> <p>Findings include:</p> <p>A review of the policy, "Food Temperatures At Serving," dated 03/01/10, revealed all hot food items would be served to the resident at the temperature of at least 140 degrees F. When the temperature was not above 140 degrees F., the food item would be reheated to 165 degrees for 15 seconds in the microwave, oven or stove top oven. Food temps would be obtained using a clean, rinsed and sanitized thermometer, numerically scaled and accurate to plus or minus two (2) degrees F. Temperatures should be taken periodically to ensure hot foods remained above 140 degrees F. until served to the resident. Thermometers should be recalibrated each morning.</p> <p>An observation of the kitchen, on 05/18/11 at 12:28 PM, revealed the Dietary Manager and Cook #1 were unable to properly calibrate a food thermometer and stated the food thermometer should be calibrated to 50 degrees Fahrenheit (F). The temperature on the food thermometer ranged between 50 degrees F. and 220 degrees F. The food thermometer was not calibrated to detect a temperature of 32 degrees F. when placed in ice water. Another thermometer was obtained and was properly calibrated by the Dietary Manager. She tested the cooked cabbage at 100 degrees F. from the steam table and reheated the cabbage in the microwave. A test tray was requested at 12:20 PM and tested at 12:44 PM. The steam table temperature of the cabbage was 140 degrees and 88 degrees F. at the point of service. The steam table temperature of the pork was 136 degrees F. and 48 degrees F. at the point of service. The tray</p>	F 364	<p>Dietary Supervisor monthly x6, then quarterly. (3) A "Dietary In-Service Schedule" has been developed to ensure that dietary staff continues to receive the proper in-service education to ensure adherence to the regulation (see attached).</p> <p>Criteria 4 - The Administrator, and/or Certified Dietary Manager consultant will oversee the CQI audits along with the Dietary In-Service Schedule. The Administrator and/or Certified Dietary Manager consultant will sign-off on the CQI audits and In-Service sign-in sheets monthly x6 to ensure ongoing compliance.</p> <p>Criteria 5 - Target Date</p>	06/15/11
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F 364	<p>Continued From page 2</p> <p>remained on the food cart for 24 minutes.</p> <p>An observation of the supper meal, on 05/18/11 at 4:45 PM, revealed the Dietary Manager tested the chicken fingers, which were fully cooked, breaded and frozen from the manufacturer, at 71 degrees F. The Dietary Manager reheated the chicken fingers twice in the microwave to obtain a temperature of 140 degrees F. Resident #9 complained the chicken fingers were "hard as a rock." He/she also complained that most foods were cooked in the microwave instead of being baked or fried, and foods served were mostly canned or frozen food.</p> <p>An interview with the Dietary Manager, on 05/18/11 at 11:30 AM, revealed the Certified Dietary Manager worked part-time at the facility and was on vacation. The Dietary Manager was unaware of the proper way to calibrate a thermometer. Additionally, she did not know if she or the dietary staff were inserviced on thermometer calibration and the proper holding temperatures by the Certified Dietary Manager. There was no documented evidence of inservicing provided by the Dietary Manager.</p> <p>A phone interview with the Certified Dietary Manager, on 05/20/11 at 2:57 PM, revealed he worked at the facility on a two-week rotation. He stated the staff were inserviced on all the required temperatures and calibrating thermometers. He also stated he had completed satisfaction surveys with the residents and had no complaints. However, there was no documented evidence of the inservicing provided by the Certified Dietary Manager.</p>	F 364			

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F 364	Continued From page 3 An interview with the Registered Dietician, on 05/19/11 at 4:45 PM, revealed she had only been able to see the dietary staff members "plate up" or serve one meal and was unaware the temperatures were below acceptable levels.	F 364		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	483.65 INFECTION CONTROL, PREVENT, SPREAD, LINENS Criteria 1 - The derma sleeves were removed from resident #2 and sent to laundry. Staff members also washed the resident's hands. SRNA #1 received an "Individual Teach and Train" provided by the Director of Nursing on 5/18/2011. All direct care staff have received in-service education regarding hand washing organized by either the Corporate Director of Clinical Operations, Director of Nursing and/or Training Coordinator. Training was completed between 5/27/2011 and 6/16/2011. Criteria 2 - The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 - The Infection Control program will be added to the CQI program and will be audited (using IC-1 and IC-2, see attached) monthly x6 and then quarterly. The DON and/or designee will complete the audits Criteria 4 - The DON and/or designee will complete the audits and will present results in the facilities' monthly CQI meeting. Criteria 5 - Target Date	06/17/11

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F 441	<p>Continued From page 4</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure staff members washed their hands and changed gloves before and after resident care for one resident (#2), in the select sample of 16.</p> <p>Findings include:</p> <p>A review of the policy for "Handwashing" (undated), revealed staff were expected to wash their hands after direct contact with the residents, contact with body fluids or excretions and after removing gloves.</p> <p>1. A record review revealed Resident #2 was admitted to the facility, on 06/16/10 and readmitted on 04/12/11, with diagnoses to include Sacral Decubitus (pressure sore). A review of the admission assessment, dated 04/22/11, revealed the facility assessed Resident #2 to require extensive assistance of two staff members for transfer and bed mobility. He/she was frequently incontinent of bowel and required a urinary catheter to promote healing of the pressure sore. The resident was admitted with a Stage III pressure sore to the coccyx area.</p> <p>A review of the care plan for skin integrity, dated</p>	F 441			

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F 441	Continued From page 5 05/17/11, revealed the resident was to be turned every hour and as needed with staff assistance of two and required incontinent care every two hours and as needed. The resident was totally dependent on two staff members for all care.  An observation during the provision of incontinent care, on 05/18/11 at 4:00 PM, revealed SRNA #1 did not change her gloves and wore the same gloves for disposing of the soiled brief. She provided incontinent care, assisted the resident with pulling his/her hand through the geri-sleeve prior to removing her gloves and touched the resident's bare hand with the soiled glove.  An interview with SRNA #1, on 05/18/11 at 4:15 PM, revealed she knew the rationale behind removing the gloves before she repositioned the resident's hand and clothing and stated, "I was just nervous."  An interview with Director of Nursing (DON), on 05/20/11 at 3:50 PM, revealed she expected the SRNAs to change gloves and wash their hands before and after perineal care and to change gloves, prior to repositioning the resident. The SRNAs were trained to wash their hands and change gloves and she stated, "They knew better".	F 441			

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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 05/17/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	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.	
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire/smoke barrier walls were capable of resisting the passage of smoke throughout the building in the event of a fire. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, residents and staff. The facility is licensed for twenty two (22) beds with a census of sixteen (16) the day of the survey.  The findings include:  Observations during the life safety code tour on 05/18/11 at 11:15 AM revealed the fire barrier wall separating the Skilled Nursing Facility from the Assisted Living Facility, had penetrations that	K 011	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of material as required for the addition. Communicating openings occurs only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1., 18.1.1.4.2 Criteria 1 – Maintenance Director has caulked around all openings with 3M Fire Barrier Caulking. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – The facility has developed a policy regarding preventative maintenance post a contractor visit (see attached). Criteria 4 – The Maintenance Director will monitor for compliance. Criteria 5 – Target Date	06/14/11

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

TITLE

(X6) DATE

*Just Ladd*

Administrator

6-17-11

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 011	Continued From page 1 were not sealed.  An interview with the Maintenance Director on 05/18/11 at 11:15 AM revealed he was unaware of the penetrations and confirmed the observation.  Reference: NFPA 101 2000 edition  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: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) 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 meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke	K 011			

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K 011	Continued From page 2 barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 011	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that six (6) of its exits had a durable surface to the public way. The deficient practice has the potential to affect five (5) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for twenty two (22) beds with a census of sixteen (16) on the day of the survey.  The findings include:  The Life Safety Code tour on 05/18/11, at 11:08 AM revealed the exterior exits located in resident corridors (1), (2), (3), the Activity Area, and Hall (A102) had a concrete pad poured five feet out and stopped at grassy dirt. There were no durable surfaces outside the exits leading to a public way.  An interview with the Maintenance Director on 05/18/11 at 11:08 AM confirmed the observation.  Exits must have a durable surface to the public way to support wheelchairs, beds, equipment, etc., in case of an emergency situation.	K 038	Criteria 1 – The facility has accepted a bid from a contractor to construct a 4 ft. (1.2m) wide concrete sidewalk from resident corridors (1), (2), (3) to a public way. The contractor plans to start as soon as weather permits. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – The facility will install 4 ft. (1.2m) wide concrete sidewalks from resident corridors (1), (2), (3) to a public way. Criteria 4 – The Administrator and/or Maintenance Director will oversee this project until completion. Criteria 5 – Target Date	7/1/2011	

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K 039 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards. The deficient practice has the potential to affect three (3) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for twenty two (22) beds with a census of sixteen (16) the day of the survey.</p> <p>The findings include:</p> <p>Observations on 05/18/11 at 12:30 PM revealed that a linen cart was being stored in resident corridor number 1, and a linen cart and an ice cart were being stored in resident corridor number 2.</p> <p>An interview with a member of the Nursing staff on 05/18/11 at 12:30 PM revealed that it was common practice to store linen carts and ice carts in the corridor areas. This observation was also confirmed with the Maintenance Director.</p> <p>Actual NFPA Standard: 19.2.3.3*</p>	K 039	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Criteria 1 – All equipment not being used will be stored in its designated location instructed by the Maintenance Director and/or designee (see attached). Equipment that is being used will be moved down the corridor as staff utilizes the equipment in different resident rooms. All carts will remain on the same side of the hallway to avoid obstruction while in use.</p> <p>Criteria 2 - The facility acknowledges that all residents have the potential to be affected by this deficient practice.</p> <p>Criteria 3 – A policy has been developed regarding the storage of equipment. The Maintenance Director has been in-serviced to monitor. Carts are not to be stored on the resident corridors when not in use.</p> <p>Criteria 4 – The Maintenance Director and/or designee will monitor for compliance.</p> <p>Criteria 5 – Target Date</p>	06/14/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B1 - BRECKINRIDGE PLACE B. WING _____		(X3) DATE SURVEY COMPLETED  05/18/2011
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 039	Continued From page 4 Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 039	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. Criteria 1 – Permanent signage has been installed outside of the storage areas. Self-closing hinges are being installed by the Maintenance Director and the door knobs are currently self-locking. Criteria 2 - The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – The signage will be permanently mounted to the storage areas and will not be easily removable to ensure ongoing compliance. Self-closing hinges are being installed by the Maintenance Director.		
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the Oxygen Storage was protected according to NFPA standards. The deficient practice has the potential to affect one (1) of eight (8) smoke compartments, residents, and staff. The facility is	K 076	Criteria 4 – The Administrator and/or Maintenance Director will oversee the project. Criteria 5 – Target Date	06/30/11	

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NAME OF PROVIDER OR SUPPLIER  BRECKINRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 170 SYKES BOULEVARD MORGANFIELD, KY 42437		
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K 076	<p>Continued From page 5</p> <p>licensed for twenty two (22) beds, with a census of sixteen (16) the day of the survey.</p> <p>The findings include:</p> <p>An observation on 05/18/11 at 12:25 PM of the Medication Room were oxygen tanks where stored, revealed the room did not have a closure or signage on the door, per NFPA requirements.</p> <p>An interview with the Maintenance Director on 05/18/11 at 12:25 PM revealed he was unaware of the requirements.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection</p>	K 076			

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NAME OF PROVIDER OR SUPPLIER  <b>BRECKINRIDGE PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>170 SYKES BOULEVARD MORGANFIELD, KY 42437</b>
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K 076	Continued From page 6 rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076	NFPA 101 LIFE SAFETY CODE STANDARD Alarms, emergency communication systems, illumination of generator set locations are in accordance with NFPA 70. 9.1.2	
K 108 SS=F	8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b> NFPA 101 LIFE SAFETY CODE STANDARD Alarms, emergency communication systems, and illumination of generator set locations are in accordance with NFPA 70. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its generator in accordance with NFPA 76, 99, 101,110, and the National Electrical Code ( NFPA 70 ) requires the facility to have a emergency illumination located at the transfer switch and at the generator location. The deficient practice has the potential to affect all smoke compartments, residents, and staff. The facility is licensed for twenty two (22) beds, with a census of sixteen (16) the day of the survey.  The findings include:  An observation on 05/18/11, at 11:55 AM revealed the generator had no emergency illumination at the transfer switch and at the	K 108	Criteria 1 - Permanent emergency illumination has been ordered and will be installed at the transfer switch and at the generator location. Criteria 2 - The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 - Once the emergency illumination has been installed at the two locations they will be added to the preventative maintenance log and will be monitored by the Maintenance Director and/or designee. Criteria 4 - The Administrator and/or Maintenance Director will oversee this project. Criteria 5 - Target Date	06/30/11

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K 108	Continued From page 7 generator location.	K 108	NFPA 101 LIFE SAFETY CODE STANDARD	
K 147 SS=D	<p>An interview on 05/18/11 at 11:55 AM with the Maintenance Director revealed that he was not aware that the generator and transfer switch had to have emergency illumination.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical wiring was maintained as required by NFPA standards. This deficient practice has the potential to affect any staff members in the Kitchen area. The facility is licensed for twenty two (22) beds, with a census of sixteen (16) the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 05/18/11 at 11:40 AM with the Director of Maintenance (DOM), an electrical outlet located near the sink in the Kitchen was tested and found not to be protected by a Ground Fault Circuit Interrupter (GFCI).</p> <p>An interview with the Director of Maintenance on 05/18/11 at 11:40 AM revealed the Director of Maintenance was unaware of the plug not having Ground Fault Protection.</p> <p>Reference: NFPA 70 (1999 Edition).</p>	K 147	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Criteria 1 – The electrical outlet located near the sink in the Kitchen has been replaced with a Ground Fault Circuit Interrupter (GFCI) on 5/27/2011 by a licensed Contractor.</p> <p>Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice.</p> <p>Criteria 3 – Deficient practice has been corrected, no other concerns found.</p> <p>Criteria 4 – The Administrator and/or Designee will oversee this project.</p> <p>Criteria 5 – Target Date</p>	05/27/11

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K 147	Continued From page 8 517-20. Wet Locations a. All receptacles and fixed equipment within the area of the wet location shall have ground-fault circuit-interrupter protection for personnel if interruption of power under fault conditions can be tolerated, or be served by an isolated power system if such interruption cannot be tolerated. Exception: Branch circuits supplying only listed, fixed, therapeutic and diagnostic equipment shall be permitted to be supplied from a normal grounded service, single- or 3-phase system, provided that a. Wiring for grounded and isolated circuits does not occupy the same raceway, and b. All conductive surfaces of the equipment are grounded. b. Where an isolated power system is utilized, the equipment shall be listed for the purpose and installed so that it meets the provisions of and is in accordance with Section 517-160. FPN: For requirements for installation of therapeutic pools and tubs, see Part F of Article 680.	K 147			