

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

PRINTED: 05/28/2010
FORM APPROVED
OMB NO. 0938-0391

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 05/21/2010
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 initial certification survey conducted on 05/20-21/10. The facility is in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	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.

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

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101101	(X2) MULTIPLE CONSTRUCTION A. BUILDING B1 - BRECKINRIDGE PLACE B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2010
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 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 05/20/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an "F".	K 000	<ul style="list-style-type: none"> The corrective action accomplished for the residents found to have been affected by the deficient practice was a remote annunciator panel that was installed in a location readily observed by operating personnel at a regular work station. The annunciator panel installation began at the nurses' station on 06/01/2010. The facility will identify other residents having the potential to be affected by the same deficient practice by installing the annunciator panel to notify staff of any change of condition to the generator. The annunciator panel was placed at the nurses' station to ensure that the deficient practice will not recur. The annunciator panel will be a monitoring tool for the condition of the generator. If the panel shows a change in condition of the generator the staff will notify the administrator or administrator designee. The nursing staff will be inserviced on the monitoring of the annunciator panel at the Unit Meeting on 06/04/2010 per Administrator. The annunciator panel will be monitored daily per charge nurse on every shift. The generator will be inspected weekly per the administrator or administrator designee and exercised weekly under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Refer to Generator Policy. 	06/04/2010	
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview conducted on 05/20/10, it was determined the facility failed to ensure that electrical wiring and standards met NFPA requirements.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code tour conducted on 05/20/10 at 2:30 PM with facility staff revealed the facility did not have an annunciator alarm for the emergency generator.</p> <p>An interview with the Administrator on 05/20/10 at 2:35 PM revealed the facility was not aware of the required annunciator alarm annunciator for the generator.</p>	K 144			



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

Amber Hulet

TITLE

RN, Administrator 06/03/10

(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.