

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

PRINTED: 06/22/2012
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 06/08/2012
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	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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156	483.10(b)(5)-(10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES Criteria 1 – The facility has developed a policy titled "Medicare Non-coverage Policy." The facility will provide the Advance Beneficiary Notice of Noncoverage (ABN) at the time Medicare Part-A no longer covers the resident's stay regardless of discharge plans or discharge location. The facility will also prominently display written information about how to apply for and the use of Medicare and Medicaid benefits as well as continue to inform the resident and/or resident's designee at admission and with the "Resident/Responsible Party Supplemental Admission Information" that is provided. Criteria 2 – No other resident was impacted by the cited deficiency. Criteria 3 – The facility has developed and adapted a "Medicare Non-Coverage Policy." The facility has posted signage informing resident(s) and/or resident's designee of how to inquire/apply for Medicare and/or Medicaid benefits. Criteria 4 - The Administrator and/or designee will review all Medicare discharges ABN x 3 months to ensure compliance. Criteria 5 – Target Date:	07/02/2012



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

TITLE

(X6) DATE

John Ladd

Administrator

7/2/2012

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 156	<p>Continued From page 1</p> <p>the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and</p>	F 156		

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F 156	<p>Continued From page 2</p> <p>procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to inform each resident of charges for services not covered under Medicare for one resident (#8), in the selected sample of eight residents. Additionally, the facility failed to prominently display written information about how to apply for and the use of Medicare and Medicaid benefits, and how to receive funds for previous payments covered by such benefits.</p> <p>Findings include:</p>	F 156		

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F 156	<p>Continued From page 3</p> <p>A review of the facility's "Residents' Rights" policy/procedure, undated, revealed the resident and the responsible party or his responsible family member or his guardian shall be fully informed in writing of all service charges for which the resident or his responsible family member or his guardian was responsible for paying. The resident and the responsible party or his guardian shall have the right to file complaints concerning charges which they deem unjustified to appropriate local and state consumer protection agencies. Every long-term care facility shall keep the original document of each written acknowledgement in the resident's personal file.</p> <p>A record review revealed the facility admitted Resident #8 on 02/21/12, and transferred the resident to the hospital on 04/17/12, with a payor source of Medicare. The resident's discharge date from the facility was 04/21/12. There was no evidence an Advance Beneficiary Notice of Noncoverage (ABN) was issued to the resident or the guardian.</p> <p>An interview with the Administrative Assistant, on 06/08/12 at 10:35 AM, revealed the ABN was not issued to the resident because the family did not want a "bed hold."</p> <p>An interview with the Administrator, on 06/08/12 at 12:00 PM, revealed he did not send an ABN if a Medicare resident was discharged to a hospital or another facility. He stated he did not think he had to do that because "they would not be getting any further services from us." Additionally, the Administrator revealed residents were provided information about applying for Medicare and Medicaid benefits upon admission; however, the</p>	F 156			

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F 156	Continued From page 4 written information was not prominently displayed in the facility. He was unable to provide a facility policy regarding this information.	F 156		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 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 services provided met professional standards of quality, related to medication administration, for one resident (#10), not in the selected sample. Findings include: A review of an untitled facility policy, undated, revealed medications would be administered accurately, according to the physician's orders. Always observe the six rights in giving medication: 1. Right individual 2. Right medication 3. Right method of administration 4. Right time 5. Right dosage 6. Right documentation A review of Resident #10's physician orders, dated 04/30/12, and Medication Administration Record (MAR), dated 06/01/12 through 06/30/12, revealed an order for Brimonidine eye drops, give two drops in each eye twice daily.	F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Criteria 1 – All licensed staff and Kentucky Medication Aides will complete the medication pass quiz and receive a copy of the Medication Pass Administration Tool. Staff will be randomly selected to participate in Medication Pass Audits that will be completed quarterly and reviewed in the Continuous Quality Improvement (CQI) meetings. Criteria 2 – The facility acknowledges that all residents have the potential to be affected by this deficient practice. Criteria 3 – The deficient practice will be corrected and will not recur. Criteria 4 – The Director of Nursing and/or designee will ensure completion by the target date and will ensure Medication Pass Audits are completed quarterly and reviewed in the CQI meeting. Criteria 5 – Target Date:	07/18/2012

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F 281	Continued From page 5 An observation of a medication pass, on 06/06/12 at 3:50 PM, revealed Kentucky Medication Aide (KMA) #2 administered Brimonidine 0.2 percent (%) eye drops, one drop in each eye, to Resident #10. An interview with KMA #2, on 06/07/12 at 4:00 PM, revealed she was nervous and only gave one eye drop, instead of two, during the medication observation. An interview with the interim Director of Nursing (DON), on 06/08/12 at 2:45 PM, revealed she expected the staff to follow the facility policy/procedure related to medication administration.	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was stored under sanitary conditions.	F 371	483.35(i) FOOD PROCEDURE, STORE/PREPARE/SERVE - SANITARY Criteria 1 – The outdated product(s) were immediately removed, disposed of and not served to any resident. Criteria 2 – No specific resident was impacted by the cited deficiency. Criteria 3 - All dietary staff has been retrained on the facility policy and procedure of checking expiration dates on refrigerated items on 06/07/2012 by the Dietary Services Manager. The Dietary Services Manager and/or designee will check and document all refrigerated items daily to ensure all expired items are disposed of timely. Criteria 4 – The Administrator will conduct a weekly unannounced inspection of the dietary department x4 weeks starting 07/02/2012 to ensure compliance and periodically thereafter. Criteria 5 – Target Date:	07/02/2012

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F 371	Continued From page 6 Findings include: A review of the facility's policy/procedure for "Food Receipt and Storage," dated 02/01/02, revealed refrigerated items should be labeled, dated, and covered. An observation of the kitchen refrigerator, on 06/06/12 at 9:50 AM, revealed the following: 1. Two containers of nectar thickened orange juice, opened 05/14/12, the label specified to discard after five days. 2. One carton of thickened dairy drink, opened with no date. 3. One carton of nectar thickened lemon flavored drink, opened with no date. 4. One carton of nectar thickened cranberry drink, opened with no date. 5. One carton of nectar thickened apple drink, opened with no date. An interview with the Dietary Manager, on 06/08/12 at 10:20 AM, revealed she expected the staff to clean out and remove expired items from the refrigerator. She revealed items in the refrigerator should be dated when opened. An interview with the Administrator, on 06/08/12 at 3:00 PM, revealed he expected the staff to follow the facility's policy/procedure related to food storage.	F 371		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		

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F 431	<p>Continued From page 7</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure the proper storage of medications in the refrigerator related to expired medications available for use. Additionally, it was determined the facility failed to ensure an account</p>	F 431	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>Criteria 1 – Licensed staff and Kentucky Medication Aides will be in-serviced on checking the refrigerator for expired medications. The refrigerator shall be checked daily for expired medications by the night shift charge nurse. The night shift charge nurse will document that this is completed by signing off on a designated sheet.</p> <p>Criteria 2 – No specific resident was impacted by the cited deficiency.</p> <p>Criteria 3 – The deficient practice will be corrected by the action taken in Criteria 1 and will not recur.</p> <p>Criteria 4 – The Director of Nursing and/or designee will ensure completion by target date.</p> <p>Criteria 5 – Target Date:</p>	07/18/2012

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F 431	<p>Continued From page 8 of all controlled drugs was maintained.</p> <p>Findings include:</p> <p>A review of the facility's "Medication Storage" policy/procedure, dated 10/15/05, revealed expired, outdated, contaminated, or deteriorated medications were to be immediately withdrawn from stock.</p> <p>An observation of the refrigerator in the medication room, on 06/06/12 at 1:45 PM, revealed the following:</p> <ol style="list-style-type: none"> 1. One vial of Fluvirin (influenza vaccine) opened, with an expiration date of 05/12. 2. Three vials of Fluvirin unopened, with an expiration date of 05/12. 3. One vial of Novolog insulin unopened, with an expiration date of 05/12. <p>An interview with Kentucky Medication Aide (KMA) #1, on 06/06/12 at 2:05 PM, revealed the nurse was responsible for the removal of expired medication in the refrigerator; however, an interview with Licensed Practical Nurse (LPN) #1, on 06/06/12 at 2:05 PM, revealed it was the KMA's responsibility.</p> <p>An interview with the interim Director of Nursing (DON), on 06/08/12 at 2:45 PM, revealed nobody had been checking the refrigerator for expired medications.</p> <p>A review of the Controlled Substances policy, dated 10/15/05, revealed a physical inventory of each controlled substance (or a change of shift audit) must occur at the end of every shift by the nurse going off duty and the nurse coming on</p>	F 431			

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F 431	Continued From page 9 duty. The change of shift audit would include a physical inventory and reconciliation of the medications against the declining inventory records, inspection of the packaging to ensure integrity and a count of the total number of medication counters or blister packs and the total number of declining inventory records. All audits would be documented on a shift change signature sheet by both nurses involved. These signatures would indicate the audit was accurate. An observation, on 06/06/12 at 1:45 PM, revealed an emergency kit in the medication room refrigerator. The emergency kit contained one vial of Ativan (narcotic) 2 milligrams (mg)/ milliliter (ml). The facility could not provide documented evidence the staff were counting the narcotics to ensure it was accounted for every shift. An interview with LPN #1, on 06/06/12 at 2:05 PM, revealed the Ativan was not counted with the other narcotics at shift change. An interview with the interim DON, on 06/08/12 at 2:45 PM, revealed staff were not, but should be, keeping an account of the Ativan in the refrigerator.	F 431			
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	F 441			

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F 441	<p>Continued From page 10</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>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 interview, personnel record review, and review of the facility's policy/procedure, it was determined the facility failed to prevent the development and transmission of disease and infection related to the timely administration of employee Tuberculin/Mantoux (TB) skin tests.</p>	F 441	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>Criteria 1 – The facility will conduct an audit to ensure all staff is up-to-date with their Post-offer and Annual Tuberculin/Mantoux requirement.</p> <p>Criteria 2 – No specific resident was impacted by the cited deficiency.</p> <p>Criteria 3 – The Office Manager and/or designee will review the personnel files of all employees to ensure that all employees are up-to-date. The Office Manager and/or designee will complete audits quarterly and provide a report of the completed audit to the Continuous Quality Improvement (CQI) meeting each quarter.</p> <p>Criteria 4 – The Administrator and/or designee will review the audit results as part of the CQI meeting each quarter.</p> <p>Criteria 5 – Target Date:</p>	07/09/2012

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(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
F 441	Continued From page 11 Findings include: A review of the facility's policy/procedure, "Post-offer and Annual Tuberculin/Mantoux Requirements," undated, revealed employees would obtain a post-offer TB skin test, be re-tested on an annual basis as mandated by Federal and State regulations, and provide to the facility a written statement of the test results. A review of Certified Nurse Aide (CNA) #1's personnel record on 06/08/12, revealed a hire date of 03/09/12. CNA #1 had a negative TB skin test on 05/27/11; however, the facility could not provide documentation of a current TB skin test. An interview with the Administrator, on 06/08/12 at 12:50 PM, revealed he was responsible for ensuring employees have current TB skin tests on file. He could not provide documentation of a current TB skin test for CNA #1.	F 441		
F 463 SS=D	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, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident's restroom was equipped to receive resident calls through a	F 463		

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

PRINTED: 06/22/2012
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OMB NO. 0938-0391

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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 463	Continued From page 12 communication system. Findings include: A review of the facility's "Call Lights" policy/procedure, undated, revealed the call light would be within reach of the resident. This included while the resident was in the room, bathroom, or shower room. During general observation of the facility, on 06/07/12 at 8:50 AM, revealed a restroom available for resident use with no emergency call system. An interview with the interim Director of Nursing (DON), on 06/07/12 at 8:50 AM, verified the restroom was available for resident use without assistance. She revealed she was not aware of the need for a call system in the restroom. An interview with the Administrator, on 06/08/12 at 3:00 PM, revealed it was considered a "public" restroom; however, he revealed it was available for resident use.	F 463	483.70(f) RESIDENT CALL SYSTEM – ROOMS/TOILET/BATH Criteria 1 – The restroom that was available for resident use during the survey is no longer available to residents for use. Criteria 2 – The facility acknowledges that multiple residents had the potential to be affected by this deficient practice. Criteria 3 – The Maintenance Director installed an automatic closure on the restroom door with an automatic locking device. The restroom is only accessible with a key that must be obtained from a staff member. Criteria 4 – The Maintenance Director, Administrator and/or designee will monitor for compliance to ensure the deficient practice will not recur. Criteria 5 – Target Date:	06/14/2012

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OMB NO. 0938-0391

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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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2009</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry and wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/06/12. Breckinridge Place was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for twenty two (22) beds with a census of twenty (20) 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 Fire)</p>	K 000		

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

John Ladd

TITLE

Administrator

(X6) DATE

8/7/2012

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

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K 000	Continued From page 1	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 017 NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for twenty two (22) beds with a census of twenty (20) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the Administrator revealed a therapy room that was part of the exit corridor by room# 18 and the dining room. The content of this room is not permitted to be in an area open to the corridor.</p> <p>Interview, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the</p>	06/27/12
K 017 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for twenty two (22) beds with a census of twenty (20) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the Administrator revealed a therapy room that was part of the exit corridor by room# 18 and the dining room. The content of this room is not permitted to be in an area open to the corridor.</p> <p>Interview, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the</p>	K 017		

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

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OMB NO. 0938-0391

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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 017	Continued From page 2 Administrator revealed this area was originally not designed as the therapy area. NFPA 101 (2000) 18.3.6.1 Corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5. (See also 18.2.5.9.) Exception No. 1: Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least	K 027		

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

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K 027	<p>Continued From page 3</p> <p>1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier were opposite swinging in accordance with NFPA standards. The deficiency had the potential to affect five (5) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for twenty two (22) beds with a census of twenty (20) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and</p>	K 027	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 ¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Criteria 1 – The facility has acquired a contractor to replace the steel frames, doors and magnetic door release system to be in compliance with the above stated code. The facility has hired a contractor to correct the cited deficiency by installing doors that swing in the opposite direction on the front of the resident corridors. The facility does not feel that the door located at the front of the skilled area applies as one panel of the door remains locked at the top and bottom at all times and is not a method of egress leaving only one door for egress at this location.</p> <p>Criteria 2 – No specific resident was impacted by the cited deficiency.</p> <p>Criteria 3 – The action taken in criteria 1 will correct the problem and it will not recur.</p> <p>Criteria 4 – The Administrator and/or Maintenance Director will oversee this project until completion.</p> <p>Criteria 5 – Target Date</p>	10/08/2012

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

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K 027	<p>Continued From page 4</p> <p>the Administrator revealed the cross-corridor doors, located at the front of the skilled area of the building and the front of the resident corridors swung in the same direction.</p> <p>Interview, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the Administrator revealed they were unaware the doors needed to swing in the opposite direction.</p> <p>Reference: NFPA 101 (2000 Edition) 18.3.7.5*. Doors in smoke barriers shall be substantial doors, such as 1-3/4-in (4.4 cm) thick, solid-bonded wood core doors, or shall be of construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Cross-corridor openings in smoke barriers shall be protected by a pair of swinging doors or a horizontal sliding door complying with 7.2.1.14. Swinging doors shall be arranged so that each door swings in a direction opposite from the other.</p> <p>Reference: NFPA 101 (2000 Edition) A.18.3.7.5. Smoke partition doors are intended to provide access to adjacent zones. The pair of cross-corridor doors are required to be opposite swinging. Access to both</p>	K 027			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 027	Continued From page 5 zones is required.	K 027			
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for twenty two (22) beds with a census of twenty (20) on the day of the survey. The findings include:</p> <p>Observation, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the Administrator revealed the side main corridor exit does not have a 4' wide durable surface to a public way. Further observation the two exits in the activity area did not have a 4' wide durable surface to a public way.</p> <p>Interview, on 06/06/12 between 2:00 PM and 3:00 PM, with the Director of Maintenance and the Administrator revealed they thought they had fixed this tag by the Plan of Correction submitted on the last survey. The doors are still marked exit and the evacuation routes are still marked on the facility map.</p>	K 038	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>The facility does not consider this is a repeat deficiency as identified on the CMS-2567 dated June 6, 2012. The facility submitted an acceptable Plan of Correction on June 17, 2011 for the previous citation and it was approved as written.</p> <p>Criteria 1 – The facility has accepted a bid from a contractor to construct a 4 ft. (1.2m) wide concrete sidewalk from the side main corridor exit and for the two exits in the activity area of the skilled nursing area to a public way. Criteria 2 – No specific resident was impacted by the cited deficiency. Criteria 3 – The facility has hired a contractor that will install 4 ft. (1.2m) wide concrete sidewalks from the side main corridor exit and from the two exits in the activity area of the skilled nursing area that will lead to a public way. Criteria 4 – The Administrator and/or Maintenance Director will oversee this project until completion. Criteria 5 - Target Date</p>	07/20/2012	

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

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K 038	Continued From page 6 This is a repeat deficiency. Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038			
K 050	CMS S&C letter 5-38 NFPA 101 LIFE SAFETY CODE STANDARD	K 050			

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

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K 050 SS=F	<p>Continued From page 7</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for twenty two (22) beds with a census of twenty (20) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 06/06/12 at 12:33 PM, with the Maintenance Director and the Administrator revealed the fire drills were not being conducted at unexpected times under varied conditions. Second shift fire drills were being conducted predictably between 3:05 PM and 4:27 PM and third shift predictably between 5:54 AM and 6:10 AM.</p> <p>Interview, on 06/06/12 at 12:33 PM, with the Maintenance Director and the Administrator</p>	K 050	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms.</p> <p>Criteria 1 - The facility will conduct fire drills on each shift quarterly. The fire drills will be conducted at varying times on each shift and will not follow any pattern or schedule.</p> <p>Criteria 2 - No specific resident was impacted by the cited deficiency.</p> <p>Criteria 3 - The Administrator will in-service the Maintenance Director on the code related to the fire drills.</p> <p>Criteria 4 - The Administrator and/or designee will audit fire drills at the quarterly Safety Meeting to ensure compliance.</p> <p>Criteria 5 - Target Date</p>	07/03/2012

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

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K 050	Continued From page 8 revealed they were unaware the fire drills were not being conducted as required. Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency	K 144		

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

PRINTED: 06/22/2012
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 06/06/2012
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 144	<p>Continued From page 9</p> <p>had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for twenty two (22) beds with a census of twenty (20) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/06/12 at 2:45 PM, with the Director of Maintenance and the Administrator revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increase risk of fire.</p> <p>Interview, on 06/06/12 at 2:45 PM, with the Director of Maintenance and the Administrator revealed they were not aware that the battery charger could not be hooked directly to the battery.</p> <p>Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p>	K 144	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Criteria 1 - The facility Maintenance Director has contacted our generator service agency to correct this deficient practice. The contractor will correct this deficient practice for the facility.</p> <p>Criteria 2 – No specific resident was impacted by the cited deficiency.</p> <p>Criteria 3 – The deficient practice will be corrected and will not recur.</p> <p>Criteria 4 - The Maintenance Director and/or designee will oversee this project and ensure completion by the target date.</p> <p>Criteria 5 - Target Date</p>	07/20/2012	