

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

PRINTED: 04/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 04/10/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343	
(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 Onsite Revisit to the 01/16/15 Recertification Survey was conducted in conjunction with Abbreviated Survey (KY#23063) on 04/08/15 through 04/10/15 and determined F-252, F-257, F-371, and F-441 were corrected on 03/01/15. KY#23063 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".  483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	{F 000}	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	5/11/2015

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

*Angela R Head*

Administrator

TITLE

(X8) DATE

5/4/2015

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 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Abuse and Neglect Policy and investigations, it was determined the facility failed to ensure two (2) of nine (9) sampled residents' (Resident #7 and #8) allegations of abuse were investigated per the facility policy. The facility's investigation was not completed as staff failed to assess all (interviewable and non-interviewable) residents timely for signs and symptoms of abuse.</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect Policy (not dated), revealed the facility would prohibit abuse of residents from any source, promote well-being of residents by providing a safe and supportive environment, and maintain the resident's right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion. Further policy review revealed the definitions of abuse included the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Following a report of suspected abuse or neglect, administration should designate a resident</p>	F 225	<p>F225</p> <ol style="list-style-type: none"> <li>Resident # 7 was interviewed by the Administrator on 04-15-2015 and reported that "Duncan "had sent another male employee into his room on 04-14-2015 to threaten him/her. CNA # 1 whose name was similar to Duncan was immediately suspended and removed from the facility. The allegation was reported and investigated and found unsubstantiated. Rsd # 7 also on 04-15-15 visualized all other male employees and denied that it was the person who had threatened him/her on Duncan's behalf. Resident also denied having any concerns with CNA # 1 when called by name and stated "he ( CNA name) ain't ever done anything to me" Rsd # 8 has a BIMs score of 99 and is un-interviewable and a skin assessment was completed 04/10/15 by the Assistant Director of Nursing with no suspicious injuries or injuries of unknown origin noted.</li> <li>ON 04/30/2015 the Assistant Director of Nursing and MDS Nurse RN Charge Nurse, and Medical Records Nurse completed skin assessments on all current non-interviewable Residents (BIMs score of 7 or less) to identify any injury of unknown origin or suspicious in nature. Any identified</li> </ol>	5/1/2015

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F 225	Continued From page 2 advocate (i.e. Social Services) to support the resident through his/her feelings about the incident and his/her reaction to involvement in the investigation. In addition, the facility's administration should initiate the investigation process by interviewing all staff and residents having knowledge of the allegation immediately.  1. Review of the facility's investigation, dated 04/08/15, and interviews with Licensed Practical Nurse (LPN) #1, on 04/08/15 at 4:00 PM; LPN #4 on 04/09/15 at 9:30 AM; the Social Service Director (SSD) on 04/10/15 at 3:45 PM; and, the Director of Nursing (DON) on 04/08/15 at 2:45 PM revealed Resident #7 alleged that a staff member (CNA #1) hit him/her and his/her roommate/spouse on 04/05/15. Further review and interview revealed the LPNs and DON conducted the skin assessments of the residents who were not interviewable (Brief Interview of Mental Status [BIMS] score of seven or below) and the SSD conducted interviews with the interviewable residents (BIMS score of eight and above). The DON and SSD stated the interviews and skin assessments were only conducted with the residents who resided on the same hall as Resident #7 and no interviews or skin assessments were conducted on the adjacent hall.  2. Record review and review of the facility's investigation revealed Resident #8 made an allegation a male entered his/her room and "ripped" his/her clothes off on 02/21/15. A skin assessment was done on Resident #8, on 02/21/15, after the allegation was made. Interviews were conducted with all staff working at the time of the alleged abuse and with interviewable residents that resided on the same	F 225	injuries of unknown origin were reported to the appropriate agencies with investigation to be completed within the appropriate time frame. In addition on 04/30/2015 the Business Office Manager, Dietary Manager, Housekeeping supervisor completed interviews with all current interviewable residents ( BIMS of 8 or greater). On 04/30/15 the Administrator reviewed all interview questionnaires to identify any concerns with potential abuse and or neglect, any concerns were immediately reported to the appropriate agency with a complete investigation.  3. All facility Staff were re-educated on 04/30/15 on the abuse and neglect policy including competency test by the Human Resources Manager, Social Services Director , Administrator, and MDS Nurse with no facility staff working after 04/30/2015 without having had this re-education and competency testing. On 04/30/15 the Regional Director of Operations and the Regional Quality Nurse re-educated the Administrator on the responsibility of the Abuse Coordinator to ensure investigations are complete and coordinated to include investigations and skin assessments where appropriate.	5/11/2015

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F 225	Continued From page 3 hall as Resident #8. However, there was no documented evidence the facility did a complete investigation, as they did not perform skin assessments on all non-interviewable residents or interviews with interviewable residents on the adjacent hall.  Interview with the Administrator, on 04/10/15 at at 3:55 PM, revealed all staff and residents should be interviewed related to an abuse allegation, and skin assessments should be performed and documented on all non-interviewable residents.	F 225	4. The Regional Director of Operations will review three investigations per month if available for at least three months to ensure a thorough investigation has been conducted to include interviews and skin assessment when appropriate. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement (QAPI) at least monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Social Service Director, MDS Nurse and Medical Records Nurse with the Medical Director attending at least quarterly.	5/1/2015	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Abuse and Neglect Policy and facility's investigations, it was determined the facility failed to follow its policy for two (2) of nine (9) sampled residents' (Resident #7 and Resident #8) investigation of allegations. The facility's policy stated the facility's investigation should include skin assessments of all non-interviewable residents and interviews with all interviewable residents.  On 04/05/15, Resident #7 was transported to the Emergency Room (ER) of a local hospital with complaints of chest pain. While in the ER,	F 226			

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F 226	<p>Continued From page 4</p> <p>Resident #7 reported to his/her attending nurse that a staff member at the long term care facility (referred to by name), slapped and was shaking him/her and his/her roommate. The nurse in ER notified the Licensed Practical Nurse (LPN) #1, who worked at the term care facility, of the allegation.</p> <p>On 02/21/15, Resident #8 reported a male entered his/her room and "ripped" his/her clothes off.</p> <p>The findings include:</p> <p>Review of the facility's Abuse and Neglect Policy, (not dated), revealed the facility would prohibit abuse of residents from any source, promote well-being of residents by providing a safe and supportive environment, and maintain the resident's right to be free from verbal, sexual, physical, mental abuse, corporal punishment and involuntary seclusion. Further policy review revealed the definitions of abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Following a report of suspected abuse or neglect, administration should designate a resident advocate (i.e. Social Services) to support the resident through his/her feelings about the incident and his/her reaction to involvement in the investigation. In addition, the facility administration should initiate the investigation process by interviewing all staff and residents having knowledge of the allegation immediately.</p> <p>1. Record review revealed the facility readmitted Resident #7 on 12/15/14 with diagnoses which included Hypertension, Chronic Pain Syndrome,</p>	F 226	<p>F226</p> <p>1. Resident # 7 was interviewed by the Administrator on 04-15-2015 and reported that "Duncan "had sent another male employee into his room on 04-14-2015 to threaten him/her. CNA # 1 whose name was similar to Duncan was immediately suspended and removed from the facility. The allegation was reported and investigated and found unsubstantiated. Rsd # 7 also on 04-15-15 visualized all other male employees and denied that it was the person who had threatened him/her on Duncan's behalf. Resident also denied having any concerns with CNA # 1 when called by name and stated "he ( CNA name) ain't ever done anything to me" Rsd # 8 has a BIMs score of 99 and is un-interviewable and a skin assessment was completed 04/10/15 by the Assistant Director of Nursing with no suspicious injuries or injuries of unknown origin noted.</p>	5/11/2015

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F 226	<p>Continued From page 5</p> <p>Diabetes Mellitus, Peripheral Vascular Disease, Non- Alzheimer's Dementia, Psychotic Disorder, and Depression. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/15/15, revealed the facility assessed Resident #7's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of eleven (11) which indicated the resident was Interviewable.</p> <p>Review of the facility's investigation, dated 04/08/15, revealed Resident #7 alleged a staff member (Certified Nursing Assistance [CNA] #1) hit him/her and his/her roommate/spouse on 04/05/15. Further review revealed there was no documented evidence the facility interviewed interviewable residents (BIMS score of eight [8] or above) to determine if they were aware of any abuse and assessed non-interviewable residents (BIMS score of less than eight [8] to determine if they had any signs and/or symptoms of abuse, as required per policy.</p> <p>Interview with CNA #2, on 04/09/15 at 2:30 PM, revealed she worked on 04/05/15 from 2:00 PM to 10:00 PM and no one had interviewed her related to abuse.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/08/15 at 4:00 PM, revealed she was informed of an abuse allegation on 04/05/15 and she notified the Director of Nursing (DON) of the abuse allegation. LPN #1 stated she escorted the accused staff member out of the facility as instructed. LPN #1 stated the Social Service Director (SSD) came to facility and initiated the interview process of the facility's investigation. LPN #1 revealed she performed a skin assessment on Resident #7 and his/her</p>	F 226	<p>2. ON 04/30/2015 the Assistant Director of Nursing and MDS Nurse RN Charge Nurse, and Medical Records Nurse completed skin assessments on all current non-interviewable Residents (BIMs score of 7 or less) to identify any injury of unknown origin or suspicious in nature. Any identified injuries of unknown origin were reported to the appropriate agencies with investigation to be completed within the appropriate time frame. In addition on 04/30/2015 the Business Office Manager, Dietary Manager, Housekeeping supervisor completed interviews with all current interviewable residents ( BIMs of 8 or greater). On 04/30/15 the Administrator reviewed all interview questionnaires to identify any concerns with potential abuse and or neglect, any concerns were immediately reported to the appropriate agency with a complete investigation.</p> <p>3. All facility Staff was re-educated on 04/30/15 on the abuse and neglect policy including competency test by the Human Resources Manager, Social Services Director, Administrator, and MDS Nurse with no facility staff working after 04/30/2015 without having had this re-education and competency testing.</p>	8/10/2015	

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F 226	<p>Continued From page 6</p> <p>roommate as instructed by SSD. LPN #1 stated she did not conduct any skin assessments on other residents.</p> <p>Interview with LPN #4, on 04/09/14 at 9:30 AM, revealed she assisted in performing skin assessments on Resident #7 and his/her roommate, on 04/05/15. Further interview revealed she was not interviewed regarding the abuse allegation and had not conducted skin assessment on other residents.</p> <p>Interview with LPN #3, on 04/10/15 at 3:30 PM, revealed the facility's process in an abuse allegation was to interview all residents with a BIMS score of eight (8) or greater, and to perform a skin assessment of all residents with a BIMS score below eight (8).</p> <p>Interview with the SSD, on 04/10/15 at 3:45 PM, revealed she conducted the interviews for abuse/neglect allegations and the skin assessments were conducted by the nursing staff. The SSD stated she was contacted on 04/05/15 regarding a physical abuse allegation of Resident #7 and went to the facility to initiate the interviewing process. She stated she interviewed Resident #7's roommate on 04/05/15 but no staff interviews were conducted. Further interview revealed the SSD conducted interviews with the other interviewable residents on the same hall as Resident #7 but no interviews were conducted with residents from the adjacent hall.</p> <p>Interview with the Director of Nursing (DON), on 04/08/15 at 2:45 PM, revealed she was informed of Resident #7's abuse allegation on 04/05/15 by LPN #1. The DON stated she began skin assessments on non-interviewable residents on</p>	F 226	<p>On 04/30/15 the Regional Director of Operations and the Regional Quality Nurse re-educated the Administrator on the responsibility of the Abuse Coordinator to ensure investigations are complete and coordinated to include investigations and skin assessments where appropriate.</p> <p>4. The Regional Director of Operations will review three investigations per month if available for at least three months to ensure a thorough investigation has been conducted to include interviews and skin assessment when appropriate. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement (QAPI) at least monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Social Service Director, MDS Nurse and Medical Records Nurse with the Medical Director attending at least quarterly.</p>	5/1/2015	

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F 226	<p>Continued From page 7</p> <p>the same hall as Resident #7 on 04/08/15; however, she failed to conduct skin assessments on residents assessed with severe cognitive impairment on the adjacent hall of the facility because the accused staff member was rarely assigned to work on that hall. The DON revealed the skin assessments performed on non-interviewable residents were not documented on a skin surface diagram, Nurses' Notes, or on the Treatment Administration Record (TAR). The DON revealed the Administrator oversees the investigative process, the SSD interviews interviewable residents, and nursing staff conducts skin assessments on non-interviewable residents.</p> <p>2. Record review revealed the facility readmitted Resident #8 on 01/08/15 with diagnoses which included Malignant Neoplasm of breast, Dementia with behavior disturbances, Non-Alzheimer's Dementia, and Psychotic Disorder. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/10/15, revealed the facility assessed Resident #8's cognition as severely impaired with a BIMS score of "99" which indicated the resident was unable to be interviewed.</p> <p>Review of the facility's abuse allegations/investigations revealed Resident #8 made an allegation of abuse/mistreatment on 02/21/15. Review of the facility's investigation revealed a skin assessment was done on Resident #8, on 02/21/15, after the allegation. Interviews were conducted with all staff working at the time of the alleged abuse and interviewable residents on the hall that Resident #8 resided on. However, further review revealed there was no documented evidence the facility performed skin</p>	F 226		5/1/2015

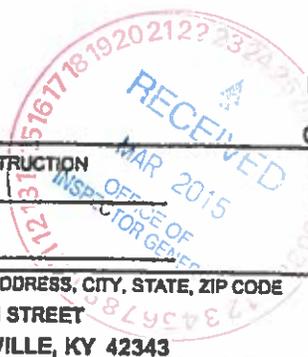
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F 226	Continued From page 8 assessments on all non-interviewable residents and interviews with all interviewable residents on the adjacent hall.  Interview with the Administrator, on 04/10/15 at 3:55 PM, revealed Resident #8 had a history of sexual trauma which occurred earlier in his/her life. The Administrator stated Resident #8 had made a previous sexual abuse allegation that was investigated by police and state agencies but it was unsubstantiated. Further interview revealed, during the process of the investigation, the facility determined the alleged perpetrator was not assigned to care for Resident #8 on 02/21/15. The Administrator stated she oversees the investigation process but she has the SSD interview the interviewable residents and the nursing staff do the skin assessments on non-interviewable interviews. The Administrator stated she expected all staff and residents to be interviewed related to an abuse allegation, and for skin assessments to be performed and documented on all non-interviewable residents.	F 226		5/1/2015	

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F 000	INITIAL COMMENTS	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	3/1/2015
F 252 SS=E	<p>A Recertification Survey was conducted on 01/13/15 through 01/16/15 with deficiencies cited at the highest Scope and Severity of a "E".</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility Maintenance and Housekeeping Supervisors Position Descriptions, it was determined the facility failed to ensure a safe, clean and comfortable homelike environment related to floor tiles in disrepair in a resident room (#22) and two (2) shower rooms. Additionally, resident rooms (#20, #22 and #27) did not have any type of window curtain or blind and resident room #14 was noted to have a consistent strong odor of urine.</p> <p>The findings include: Review of Position Description of Housekeeping Supervision, (undated), revealed the supervisor should maintain the nursing home in a clean, sanitary, orderly and attractive manner; to provide a suitable environment for the care of residents, visitors and staff. Review of the Position Description for</p>	F 252		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chrylia R Head TITLE: Administrator (X6) DATE: 3/20/2015

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/16/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(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 252	<p>Continued From page 1</p> <p>Maintenance Supervisor, (undated), revealed the supervisor should supervise, coordinate and perform the activities of the maintenance department to ensure the center was maintained in good repair and all systems were in compliance with applicable safety and fire regulations and Federal, State and local building codes to ensure a safe, comfortable environment.</p> <p>1. Observations, on 01/13/15 at 1:00 PM, on 01/14/15 at 3:00 PM and on 01/16/15 at 11:00 AM, revealed the window to the outside in resident room #20 had a curtain rod in place but there was no window curtain or blind. In addition, rooms #22 and #27 had no window curtain or blind and no curtain rod or bracket for a blind. Further observations revealed missing floor tiles in room #22 and in the shower room on the Fox's Drive Unit and on the Harmony Unit.</p> <p>Interview with the resident residing in room #22 on 01/16/15 at 1:30 PM revealed there had never been a curtain to cover the window and staff would pull the privacy curtain from between the beds that was attached to the ceiling around to cover the window opening.</p> <p>Interview with the Housekeeping Supervisor, on 01/16/15 at 1:30 PM, revealed window curtains, blinds and the missing floor tiles were the responsibility of maintenance and she knew nothing about them.</p> <p>2. Observation of resident room #14, on 01/15/15 at 2:15 PM and on 01/16/15 at 3:15 PM, revealed a strong odor of urine that was originating from a chair located in the room.</p> <p>Interview with Housekeeping Staff #1, on</p>	F 252	<p>F252</p> <ol style="list-style-type: none"> <li>On 2/6/15 the Maintenance Director installed new blinds to the windows in rooms #20, #22 and #27. Floor tiles in room #22 and both shower rooms will be replaced by 03/01/2015. The recliner in rm #14 will be replaced by 03/01/2015.</li> <li>On 2/10/15 the Administrator, Maintenance Director and Housekeeping Supervisor audited all current resident rooms to assure no other windows were missing curtains or blinds, or odors present. No new concerns were identified. The Maintenance Director will audit all floor tiles in the facility to identify any broken floor tile, any identified will be replaced by the maintenance director by 03/01/2015.</li> <li>The Administrator will educate the Maintenance Director and Housekeeping Supervisor on the requirement that all windows must have some type of curtains or blinds. The Administrator re-educated the housekeeping supervisor on daily rounds to identify concerns with odors or cleanliness. The Administrator</li> </ol>	3/1/2015	

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F 252	Continued From page 2 01/15/15 at 2:20 PM, revealed the urine odor was coming from a brown recliner located in the room. Housekeeping staff #1 cleaned the chair with a cleaning solution at the time and stated the chair had been problematic in the past. She revealed housekeeping was responsible to ensure it was clean and odor free.  Further observation, on 01/16/15 at 3:15 PM (one day later) revealed the brown recliner continued to have a strong urine odor which could be detected from the hall.  Interview with the Administrator and Director of Nursing, on 01/16/15 at 11:00 AM, revealed the window coverings were a housekeeping issue and they expected housekeeping staff to go to the Housekeeping Supervisor to ensure window coverings were obtained for the resident room windows. In addition, they stated the odor in room #14 had been an issue in the past and was unacceptable. Further interview with the Administrator, on 01/16/15 at 12:40 PM, revealed maintenance was responsible for ensuring floor tiles were replaced as needed in resident rooms and in the resident shower rooms. The Administrator stated the Maintenance Supervisor had terminated his employment in the past couple of days.	F 252	will re-educate the maintenance director on completing weekly audits for facility repair needs. The above re-education will be completed by 03/01/2015  4. The Maintenance Director and Housekeeping Supervisor and Administrator will complete an audit on the facility weekly for at least twelve (12) weeks to identify concerns with odors, cleanliness, repair concerns or needed window treatments. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement (QAPI) at least monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Social Service Director, Maintenance Director and the Housekeeping Supervisor with the Medical Director attending at least quarterly.	3/1/2015	
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS  The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F	F 257			

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F 257	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of the Position Description of the Maintenance Manager, , it was determined the facility failed to ensure it provided comfortable and safe temperature levels in resident shower rooms that were in the acceptable range of seventy one (71) degrees Farenheit to eighty one (81) degrees Farenheit.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 01/16/15 at 12:30 PM, revealed there was no documented policy related to comfortable temperatures in resident shower rooms.</p> <p>Review of the Position Description for Maintenance Supervisor, (undated), revealed the Maintenance Supervisor should supervise, coordinate and perform the activities of the maintenance department to ensure the center was maintained in good repair and all systems were in compliance with applicable safety and fire regulations and Federal, State and local building codes to ensure a safe, comfortable environment. The essential function of the position was to provide a continuous supply of heat, steam, electric power, gas or air required for operations by maintaining utility systems.</p> <p>Observation of the resident shower room located on the Fox Drive Unit, on 01/16/15 at 12:30 PM, revealed a room air temperature of sixty six (66) degrees Farenheit.</p> <p>Observation of the resident shower room located on the Harmony Unit, on 01/16/15 at 12:40 PM,</p>	F 257	<p>F257</p> <ol style="list-style-type: none"> <li>1. A contractor will install radiant heat in the shower room on Fox's Drive and Harmony Way. The completion date for this will be 03/01/2015. We are going to install radiant heat in the shower room on Fox's Drive and Harmony Way. The completion date for this is by 03/01/2015.</li> <li>2. On 2/11/15 the Maintenance Director conducted temperature readings through out the facility and no other concerns were identified. Beginning 1/17/2015 NHA and Maintenance Director began monitoring the temperatures in the shower rooms to ensure the shower rooms were above 71 degrees before use until the thermostats were moved on 2/11/2015. Once the thermostats were moved on 2/11/15 by contractors the temperatures were maintained well above 71 degrees. The radiant heaters will be installed in both shower rooms by the Maintenance Director by 3/1/2015.</li> </ol>	3/1/2015	

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F 257	<p>Continued From page 4 revealed a room air temperature of sixty one (61) degrees Fahrenheit.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 01/16/15 at 11:50 AM, revealed the shower rooms were cold and she would use her discretion to do a bed bath instead of using the shower room. She stated there was no thermometer located in the shower rooms and she had no idea how cool the shower rooms were on certain days.</p> <p>Interview with CNA #6, on 01/16/15 at 12:00 PM, revealed she gives showers to residents often and did notice the room was cold at times. She stated she would put a towel in the window to keep the air from blowing in.</p> <p>Interview, conducted 01/16/15 at 12:05 PM with unsampled Resident #A, revealed the shower rooms were cold sometimes and made it uncomfortable to have a shower.</p> <p>Interview with unsampled Resident #B, on 01/16/15 at 12:08 PM, revealed he/she didn't use the shower room frequently but when he/she did it had been cold in there.</p> <p>Interview conducted with unsampled Resident #C, on 01/16/15 at 12:15 PM, revealed it was cold in the shower room and staff would have to turn the hot water on just so he/she could stand it.</p> <p>Interview with the Administrator who observed and obtained the cool air temperatures of the shower rooms revealed at the time, that there were no records she could find that indicated temperatures had been monitored by the Maintenance Director. She stated the</p>	F 257	<p>3. The Administrator will educate the Maintenance Director by 2/10/15 on the requirement that facility temperatures should be between 71 and 81 degrees Fahrenheit</p> <p>4. The Maintenance Director will complete an audit of facility temperatures including shower rooms after installation of the new heaters weekly for twelve (12) weeks. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement (QAPI) at least monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Social Service Director, Maintenance Director and the Housekeeping Supervisor with the Medical Director attending at least quarterly.</p>	3/1/2015	

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F 257	Continued From page 5 Maintenance Director had suddenly, without warning, terminated his employment at the facility in the past couple of days and she had no way to verify if the temperatures of the shower rooms was being monitored. The Administrator stated the shower rooms were too cool for residents to shower in.	F 257			
F 371 SS=E	483.35(l) 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 policy and procedures, it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observation in the kitchen on 01/14/15, 01/15/15 and 01/16/15 revealed the stove was in disrepair, a hole was observed in the wall of a storage area, a sanitation solution was not at an acceptable level, and there were grimy surface areas and oven mitts soiled with old dried food debris.  Review of the Census and Condition, dated 01/14/15, revealed the facility had a census of sixty-three (63) with four (4) residents receiving	F 371	F371  1. The hole in the wall in the small food storage area will be repaired by the maintenance director by 03/01/2015. The shelf located over the stove area has been cleaned as noted by the Dietary services manager on 2/10/2015. The drip pans have been cleaned as noted by the dietary services manager on 02/10/2015. The oven will be replaced by 03/01/2015. Storage bins were cleaned and noted to be clean on 02/10/2015 by the dietary services manager. The mitts were washed on 01/14/2015 as noted by the dietary services manager and will be discarded	3/1/2015	

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F 371	<p>Continued From page 6 tube feedings.</p> <p>The findings include:</p> <p>Review of facility Food Services policy and procedure, last revised 2008, revealed the food service area should be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment should be kept clean, maintained in good repair and should be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use of proper cleaning. The seals, hinges and fasteners should be kept in good repair. Sanitation solution should be changed at least once per shift and if the solution becomes cloudy or visibly dirty. The kitchen and dining room surfaces not in contact with food should be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.</p> <p>1. Observation during the initial tour of the kitchen, on 01/14/15 at 11:00 AM revealed:</p> <p>A) A small food storage area to have a significant hole in the wall where food was stored.</p> <p>B) The shelf located over the stove had a thick sticky build up of grime and imprints of round cooking vessels could be seen.</p> <p>C) The drip pans had a build up of old spills and french fries.</p> <p>D) The oven door, which was in use, was not adequately functioning and was secured closed with a spoon and one of the burners was non functional.</p>	F 371	<p>and replaced by 03/01/2015. The cooler and refrigerator including the door have been cleaned and were noted free of grime by the dietary services manager on 02/01/2015. On 02/11/2015 the dietary services manager noted that the sanitation bucket tested at acceptable range.</p> <p>2. The dietary services manager will conduct a sanitation audit by 02/15/2015 and any identified areas of concern will be immediately corrected. The maintenance director will conduct an audit of the kitchen areas by 03/01/2015 and any noted repairs will be made by 03/01/2015.</p> <p>3. All dietary staff was inserviced about following the assigned cleaning schedule and testing of the sanitation solution. Training completed by the dietary manager. No dietary staff will work after 03/01/2015 without having had this re-education. The Administrator will re-educate the maintenance director by 03/01/2015 on the requirement for a monthly walk through of the kitchen to identify any environmental repair issues.</p>	3/1/2015	

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F 371	Continued From page 7 E) Storage bins were observed with a build up of grime and oven mitts stored in a drawer and available for use were soiled with old dried food debris. F) The cooler and refrigerator door top edges were also observed with a build up of grime.  2. Observation of a sanitation bucket being tested by the Dietary Manager, on 01/16/15 at 9:35 AM, revealed the sanitation solution level was at 100 parts per milliliter (ppm) instead of the acceptable 200 ppm.  Interview with the Dietary Manager, on 01/16/15 at 9:50 AM, revealed the stove shelf was not listed on the cleaning schedule but felt kitchen staff had "just missed it" as well as the storage bins. She stated the stove shelf "looks like it needs a scrubber" in order to be cleaned and the surface areas with a build up of grime should have been cleaned. She revealed she was responsible for ensuring the kitchen staff were doing the cleaning. The Dietary Manager stated the sanitation solution needed to have been changed and the oven door had not functioned properly for at least a couple of months. She stated she was unaware of when the oven mitts had last been washed, and she was responsible to ensure they were clean.  Interview with the Director of Nursing (DON), on 01/16/15 at 11:00 AM, revealed she felt the Dietary Manager was aware of the sanitation issues in the kitchen and that the facility expected nothing less than an "A".	F 371	4. The dietary services manager will complete a sanitation audit weekly to identify any cleanliness issues and that staff are testing and maintaining appropriate sanitation solution at the correct parameters for twelve (12) weeks. The maintenance director will conduct a monthly audit for repair issues monthly for three months. The results of these observations will be forwarded to the Quality Assurance Committee for three (3) months for further recommendations. If at any time concerns are identified the Quality Assurance Committee will meet to review and make further recommendations.	3/1/2015	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 8  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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441  1. On 2/9/15 the Director of Nursing re-educated CNA #1 on perineal care/incontinent care. An Observation by the Director of Nursing on 2/10/15 with CNA #1 included the observation of perineal care/incontinent care with resident #8. CNA #1 was noted to wash hands after removing gloves. In addition CNA #1 was noted to don clean gloves before applying cream to resident #8's buttocks.  2. On 02/10/2015 the Director of Nursing completed observations of Pericare and hand washing and no further concerns were identified.  3. All Certified Nurse assistants were re-educated with competency check off on perineal care/incontinent care and hand washing. Training was completed by Director of Nursing and Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Record Nurse. No Certified Nurse Aide will work after 03/01/2015 without receiving this re-education and competency check off.	3/1/2015	

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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
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F 441	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policies, it was determined the facility failed to ensure proper incontinent care and appropriate hand washing and gloving technique during the performance of perineal (incontinence) care for one (1) of thirteen (13) sampled residents (#8). The Certified Nurse Aide (CNA) failed to change gloves and wash hands prior to applying cream to Resident #8's buttocks after providing incontinent care for the removal of feces.</p> <p>The findings include:</p> <p>Review of the facility's Perineal Care/Incontinent Care policy, no date, revealed employees should wash hands and change gloves if gloves become soiled.</p> <p>Record review revealed the facility admitted Resident #8 on 07/08/14 with diagnoses which included Hypertension, Hypothyroidism, Altered Mental Status, Atrial Fibrillation, and Dementia.</p> <p>Review of the Initial Minimum Data Set (MDS) assessment, dated 07/15/14, revealed the facility assessed Resident #8's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "7" indicating the resident was not interviewable.</p> <p>Record review revealed Resident #8 was diagnosed with a Urinary Tract Infection on 01/07/15. Review of the Culture and Sensitivity Report, dated 01/07/15 revealed the urine grew the organism Enterococcus Fecalls and Resident #8 was treated with Macrobid 100 milligrams</p>	F 441	<p>4. The Director of Nursing/Assistant Director of Nursing, Unit manager, MDS Nurse or Medical Records Nurse will observe one perineal care with/ hand washing observation per shift five (5) times per week for twelve (12) weeks to ensure proper infection control procedures are followed. The results of these observations will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations.</p>	3/1/2015	

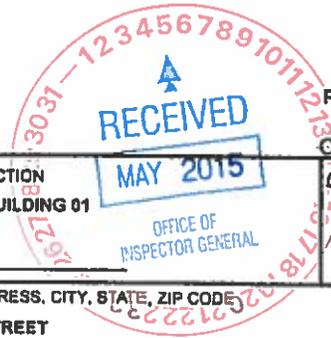
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/16/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(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 441	<p>Continued From page 10 every twelve hours for seven days.</p> <p>Observation of perineal care, on 01/16/15 at 9:25 AM, revealed CNA #1 and CNA #2 washed hands, applied gloves and explained incontinent care to Resident #8. CNA #1 used Premoistened wipes to clean stool from the resident, then picked up a tube of Baza cream and applied the cream to Resident #8's reddened buttocks without removing his/her gloves or washing his/her hands.</p> <p>Interview with CNA #1, on 01/16/15 at 9:35 AM, revealed he/she should have washed hands and put on clean gloves after cleaning the stool and before touching the Baza cream tube and applying the cream to Resident #8's buttocks.</p> <p>Interview with the Director of Nursing (DON), on 01/16/15 at 10:50 AM, revealed staff knew not to touch the tube prior to removing soiled gloves and washing his/her hands and the staff member was nervous because the surveyor was observing the procedure. The DON stated she expected staff to remove gloves, wash hands, and wear new gloves after cleaning stool and prior to touching anything.</p>	F 441			

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

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OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  R 04/09/2015
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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343
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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)	(X5) COMPLETION DATE
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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: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, upgraded in 2010 with 20 smoke detectors and 1 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965, and upgraded in 2009.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is LP.</p> <p>A Life Safety Code Revisit Survey to the 01/15/15 survey was conducted on 04/09/15. K26, K27, K29, K38, K45, K46, K47, K64, K68, and K147 were determined to be corrected; however, deficient practice continued at K25. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-seven (67) beds with a census of sixty-three (63) on the day of the survey.</p>	{K 000}	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	5/1/2015
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angelia R Head</i>	TITLE Administrator	(X6) DATE 5/4/2015
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  R 04/09/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343	
(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}	Continued From page 1	{K 000}		
{K 025}	<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>A Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b> SS=F</p> <p>Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).</p> <p>The findings include:</p>	{K 025}		5/1/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  R 04/09/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343	
(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 025}	Continued From page 2  Observation, on 04/09/15 at 11:00 AM, with the Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located in the Foxes Hall had a four (4) inch by four (4) inch hole cut into the wall that was not sealed.  Interview, on 04/09/15 at 11:01 AM, with the Maintenance Supervisor revealed they paid a company to seal the penetration and was not aware the penetration had not been sealed.  The census of sixty-three (63) was verified by the Administrator on 04/09/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/09/15.  Actual NFFA Standard:  NFFA 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: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (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 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose.	{K 025}	K025  1. The penetrations in the smoke barrier wall on Foxes Drive, above room 16 will be repaired with concrete mortar by the contractors by 04/20/2015. 2. On 04/09/2015 the maintenance director will conduct an audit of all smoke barrier walls in the attic to determine if any other penetrations are present. Any identified will be repaired by 04/20/2015. 3. On 04/09/2015 the Administrator will re-educate the Maintenance Director on the regulation requiring no penetrations in the smoke barriers. 4. The Maintenance Director will conduct monthly audits times three (3) months of the attic to identify concerns with penetrations in the smoke barriers. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, and Social Services Director with the Medical Director attending at least quarterly	5/1/2015

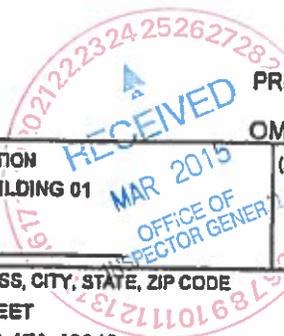
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  R 04/09/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(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 025}	Continued From page 3 (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.  8.3.8.2 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}		5/1/2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343
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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)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1965, upgraded in 2010 with 20 smoke detectors and 1 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965, and upgraded in 2009.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is LP.</p> <p>A standard Life Safety Code survey was initiated on 01/13/15 and concluded on 01/14/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-seven (67) beds with a census of sixty-three (63) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	3/1/2015
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angelia R Head</i>	TITLE <i>Administrator</i>	(X6) DATE 3/20/2015
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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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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343	
(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	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).  The findings include: 1) Observation, on 01/14/15 at 8:40 AM, with the	K 025	K025  1. The unsealed penetrations around pipes and wires in the smoke barrier above the conference room and the medical records office as well as the hole in the smoke barrier wall on Foxes drive will be repaired by a contractor by 03/01/2015. 2. On 03/01/2015 the maintenance director will conduct an audit of all smoke barrier walls in the attic to determine if any other penetrations are present. Any identified will be repaired by 03/01/2015. 3. On 02/10/2015 the Administrator will re-educate the Maintenance Director on the regulation requiring no penetrations in the smoke barriers. 4. The Maintenance Director will conduct monthly audits of the attic to identify concerns with penetrations in the smoke barriers. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to	2/1/2015

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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
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K 025	<p>Continued From page 2</p> <p>Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located by Conference Room had unsealed penetrations around pipes and wires.</p> <p>Interview, on 01/14/15 at 8:41 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations.</p> <p>2) Observation, on 01/14/15 at 8:45 AM, with the Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located over the Medical Records Office had penetrations around wires.</p> <p>Interview, on 01/14/15 at 8:46 AM, with the Maintenance Supervisor revealed he was not aware of the penetrations.</p> <p>3) Observation, on 01/14/15 at 9:00 AM, with the Maintenance Supervisor revealed the smoke barrier, extending above the ceiling located in the Foxes Hall had a four (4) inch by four (4) inch hole cut into the wall that was not sealed.</p> <p>Interview, on 01/14/15 at 9:01 AM, with the Maintenance Supervisor revealed he was not aware of the penetration.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic</p>	K 025	<p>review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, and Social Services Director with the Medical Director attending at least quarterly.</p>	3/1/2015	

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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
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K 025	Continued From page 3 tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (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 1. Be filled with a material capable of maintaining 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 026 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 026			

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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(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 026	<p>Continued From page 4</p> <p>Space is provided on each side of smoke barriers to adequately accommodate those occupants served. 19.3.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide space on each side of the smoke barrier to adequately accommodate those occupants served in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).</p> <p>The findings include:</p> <p>Observation, on 01/14/15 at 9:45 AM, with the Maintenance Supervisor revealed the size of the smoke compartments could not accommodate all residents in the event of an internal evacuation.</p> <p>Interview, on 01/14/15 at 9:46 AM, with the Maintenance Supervisor revealed he was not aware of the requirements.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard: NFPA 101 (2000 Edition). 19.3.7.4</p>	K 026	<p>K026</p> <ol style="list-style-type: none"> <li>1. A Contractor will construct a smoke barrier wall in the attic above the masonry block wall separating resident room #2 and the laundry area, also over the masonry wall between the DON office and nurses station on the opposite side of hall. The pass through door between the med room and DON office will be removed and replaced with fire rated materials. There are already smoke doors on the lower level in the hall. This will create an additional smoke compartment and will be completed by 03/01/2015.</li> <li>2. A Contractor will construct a smoke barrier wall in the attic above the masonry block wall separating resident room #2 and the laundry area, also over the masonry wall between the DON office and nurses station on the opposite side of hall. The pass through door between the med room and DON office will be removed and replaced with fire rated materials. There are already smoke doors on the lower level in the hall. This will create an additional smoke compartment and will be completed by 03/01/2015.</li> <li>3. The facility will review the new</li> </ol>	3/1/2015	

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K 026	Continued From page 5 Not less than 30 net ft <sup>2</sup> (2.8 net m <sup>2</sup> ) per patient in a hospital or nursing home, or not less than 15 net ft <sup>2</sup> (1.4 net m <sup>2</sup> ) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft <sup>2</sup> (0.56 net m <sup>2</sup> ) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments.	K 026	evacuation plan with the fire marshal by 03/01/2015 for approval. 4. The facility QAPI committee will review the facility evacuation plan and size of smoke compartments monthly for three months. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly	3/1/2015	
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 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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  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 would resist the passage of smoke in accordance with NFPA standards. The deficient practice has the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-seven (67)	K 027	K027 1. On 02/12/2015 the maintenance Director adjusted the coordinating devices on Foxes Hall and Harmony Way and both door were noted to close correctly to prevent the passage of smoke. 2. On 02/12/2015 the maintenance Director adjusted the coordinating devices on Foxes Hall and Harmony Way and both door were noted to close correctly to prevent the passage of smoke. 3. On 02/10/2015 the Administrator provided education to the Maintenance Director on the		

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K 027	<p>Continued From page 6 beds and at the time of the survey, the census was sixty-three (63).</p> <p>The findings include:</p> <p>1) Observation, on 01/14/15 at 10:16 AM, with the Maintenance Supervisor, revealed the cross-corridor doors located in the Foxes Hall would not close completely when tested. This was due to the coordinating devices installed on the doors not being adjusted properly.</p> <p>Interview, on 01/14/15 at 10:16 AM, with the Maintenance Supervisor revealed he was not aware the doors were out of adjustment.</p> <p>2) Observation, on 01/14/15 at 10:58 AM, with the Maintenance Supervisor, revealed the cross-corridor doors located in the Harmony Hall by the Medical Records Office would not close completely when tested. This was due to the coordinating devices installed on the doors not being adjusted properly.</p> <p>Interview, on 01/14/15 at 10:59 AM, with the Maintenance Supervisor revealed he was not aware the doors were out of adjustment.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p>	K 027	<p>requirement for cross-corridor doors to close completely to prevent the passage of smoke.</p> <p>4. The Maintenance Director will audit all cross-corridor doors weekly for twelve (12) weeks to ensure the coordinating device is adjusted to close properly. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly</p>	3/1/2015	

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K 027	Continued From page 7 Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.  Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.  Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition)  2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		3/1/2015	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029			

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K 029	<p>Continued From page 8</p> <p>option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, sixty (60) residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and the census was sixty-three (63) on the day of the survey.</p> <p>The findings include:</p> <p>1) Observation, on 01/14/15 at 8:30 AM, with the Maintenance Supervisor revealed ten (10) boxes of paper stored in the Lobby outside of the Administrators Office door.</p> <p>Interview, on 01/14/15 at 8:31 AM, with the Maintenance Supervisor revealed he was aware the paper should be stored in a room rated for hazardous storage; however, he was not aware the paper had been left in the lobby.</p> <p>2) Observation, on 01/14/15 at 10:20 AM, with the Maintenance Supervisor revealed the Activities Office had hazardous amount of</p>	K 029	<p>K029</p> <ol style="list-style-type: none"> <li>On 01/15/2015 the boxes of paper were removed from the lobby. Self-closures will be installed on the Activities Office doors, soiled utility room door, serving window in dining room, Dietary Storage room, Harmony Hall Shower room. These will be installed by the maintenance director by 03/01/2015.</li> <li>The Maintenance Director will conduct an audit of the facility to identify any areas with combustible material to ensure there is a self-closure installed and working properly. This will be completed by 03/01/2015. Any identified concern will be corrected by 03/01/2015.</li> <li>The Administrator on 02/10/2015 educated the Maintenance Director on the requirement for areas with hazardous amounts of combustible material to have a self-closure installed.</li> <li>The Maintenance Director will audit the facility monthly for three months to determine if any areas that store hazardous amounts of combustible material have a self-closure. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to</li> </ol>	3/1/2015	

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K 029	<p>Continued From page 9</p> <p>combustible storage. The Activities Office had a self-closing device installed; however the closers control arm had been removed. The removal of the control arm prevented the door from being self-closing as required.</p> <p>Interview, on 01/14/15 at 10:21 AM, with the Maintenance Supervisor revealed he was not aware the control arm had been removed from the self-closing device.</p> <p>3) Observation, on 01/14/15 at 10:22 AM, with the Maintenance Supervisor revealed the Soiled Utility Room located in the Foxes Hall had hazardous amount of combustible storage. The Soiled Utility Room had a self-closing device installed; however the closers control arm had been removed. The removal of the control arm prevented the door from being self-closing as required.</p> <p>Interview, on 01/14/15 at 10:23 AM, with the Maintenance Supervisor revealed he was not aware the control arm had been removed from the self-closing device.</p> <p>4) Observation, on 01/14/15 at 10:36 AM, with the Maintenance Supervisor revealed the serving window from the Kitchen to the Dining Room had a self-closing device installed; however the closers control arm had been removed. The removal of the control arm prevented the door from being self-closing as required.</p> <p>Interview, on 01/14/15 at 10:37 AM, with the Maintenance Supervisor revealed he was not aware the control arm had been removed from the self-closing device.</p>	K 029	<p>review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly</p>	3/1/2015	

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K 029	<p>Continued From page 10</p> <p>5) Observation, on 01/14/15 at 10:55 AM, with the Maintenance Supervisor revealed the Dietary Dry Storage Room had a self-closing device installed; however the closers control arm had been removed. The removal of the control arm prevented the door from being self-closing as required.</p> <p>Interview, on 01/14/15 at 10:56 AM, with the Maintenance Supervisor revealed he was not aware the control arm had been removed from the self-closing device.</p> <p>6) Observation, on 01/14/15 at 11:00 AM, with the Maintenance Supervisor revealed the Harmony Hall Shower Room was being used to store clean linens and the door was not equipped with a self-closing device.</p> <p>Interview, on 01/14/15 at 11:01 AM, with the Maintenance Supervisor revealed he was not aware the door to the Harmony Hall Shower Room needed to be self-closing.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas</p>	K 029		3/1/2015	

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K 029	Continued From page 11 shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.  Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A	K 029		3/1/2015

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K 029	Continued From page 12 door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		3/1/2015	
K 038 SS=D	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. 19.2.1	K 038	K038  1. The dead bolt lock on the Director of Nursing office and the Activities		

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K 038	Continued From page 13  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure locks on doors in the path of egress were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).  The findings include:  1) Observation, on 01/14/15 at 8:31 AM, with the Maintenance Supervisor revealed a dead bolt lock installed on the Director of Nursing Office. The lock was installed at fifty-one (51) inches above the finished floor.  Interview, on 01/14/15 at 8:32 AM, with the Maintenance Supervisor revealed he was not aware of the installation height requirements for locks.  2) Observation, on 01/14/15 at 10:20 AM, with the Maintenance Supervisor revealed a dead bolt lock installed on the Activities Office door. The lock was installed at fifty-one (51) inches above the finished floor.  Interview, on 01/14/15 at 10:21 AM, with the	K 038	Office door will be removed by 03/01/2015 by the maintenance director.  2. The Maintenance Director will conduct an audit of all doors to ensure that there are no dead bolt lock. All other dead bolt locks will be removed by 03/01/2015.  3. The Administrator will educate the Maintenance Director by 03/01/2015 on the height requirement for dead bolt locks.  4. The Maintenance Director will audit the facility monthly for three months to determine if any areas that store hazardous amounts of combustible material have a self-closure. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly	3/1/2015	

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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)	(X5) COMPLETION DATE
K 038	<p>Continued From page 14</p> <p>Maintenance Supervisor revealed he was not aware of the installation height requirements for locks.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished</p>	K 038		3/1/2015

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K 038	<p>Continued From page 14</p> <p>Maintenance Supervisor revealed he was not aware of the installation height requirements for locks.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished</p>	K 038		1/14/2015

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K 038	Continued From page 15 floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038	<p>K045</p> <ol style="list-style-type: none"> <li>1. A contractor will install lighting on the sidewalk area to illuminate the sidewalk by 03/01/2015 to meet egress lighting standards.</li> <li>2. The maintenance director will conduct an audit of all egress to determine if any other means of egress were illuminated by 03/01/2015 any concerns will be corrected immediately.</li> <li>3. The Administrator on 02/10/2015 Re-educated the Maintenance Director on the requirement that all means of egress have adequate lighting.</li> <li>4. The maintenance director will audit all means of egress monthly for three months to ensure lighting is adequate. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly</li> </ol>	3/1/2015
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress lighting was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, thirty-four (34) residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).</p> <p>The findings include:</p> <p>Observation, on 01/14/15 at 10:01 AM, with the Maintenance Supervisor revealed the facility failed to provide egress lighting outside of Foxes Hall for the full length of the sidewalk to illuminate the path of egress to the public way. A light fixture was installed at the exit door; however the sidewalk runs the length of the building.</p> <p>Interview, on 01/14/15 at 10:02 AM, with the</p>	K 045		

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K 045	Continued From page 16 Maintenance Supervisor revealed he was not aware the exit discharge did not have proper egress lighting.  The census of sixty-three (63) was verified by the Administrator on 01/14/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.  Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition) 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the	K 045		3/1/2015

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K 045	Continued From page 17 means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. 7.8.1.5 The equipment or units installed to meet the requirements of Section 7.10 also shall be permitted to serve the function of illumination of means of egress, provided that all requirements of Section 7.8 for such illumination are met. 7.8.2 Sources of Illumination. 7.8.2.1* Illumination of means of egress shall be from a source considered reliable by the authority having jurisdiction. 7.8.2.2 Battery-operated electric lights and other types of portable lamps or lanterns shall not be used for	K 045		3/11/2015

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K 045	Continued From page 18 primary illumination of means of egress. Battery-operated electric lights shall be permitted to be used as an emergency source to the extent permitted under Section 7.9.	K 045			
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, eight (8) residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).  The findings include:  Observation, on 01/14/15 at 10:05 AM, with the Maintenance Supervisor revealed the battery powered emergency light located by Room #18 failed to illuminate when tested.  Interview, on 01/14/15 at 10:06 AM, with the Maintenance Supervisor revealed he was not aware the battery powered emergency light located by Room #18 had stopped working.  The census of sixty-three (63) was verified by the Administrator on 01/14/15. The survey findings	K 046	K046  1. The battery powered emergency light located by rm #18 will be replaced by 03/01/2015 by the maintenance director. 2. The battery powered emergency light located by rm #18 will be replaced by 03/01/2015 by the maintenance director. 3. On 02/10/2015 the Administrator educated the Maintenance Director on the requirement for battery powered emergency light to function at all times. 4. The Maintenance Director will audit the emergency battery powered emergency light monthly for three (3) months. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further	3/1/2015	

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NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343
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K 046	<p>Continued From page 19 were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less</p>	K 046	<p>recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly</p>	3/1/2015
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K 046	Continued From page 20 than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 047 SS=0	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).  The findings include:  Observation, on 01/14/15 at 10:40 AM, with the Maintenance Supervisor revealed the Kitchen did not have an exit sign installed to insure the path of egress was clearly recognizable.  Interview, on 01/14/15 at 10:41 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for exit signage.  The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were	K 047	K047 1. A lighted exit sign will be installed by a contractor in the kitchen by 03/01/2015. 2. By 03/01/2015 the maintenance director will audit all exits and exit pathways to ensure all have appropriate signage. Any required will be placed by 03/01/2015. 3. The Administrator will re-educate the maintenance director by 02/10/2015 that exit and directional signs are displayed in continuous illumination. 4. The maintenance director will audit all exits monthly for three months to ensure all have appropriate signage and lighting. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly	3/1/2015

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K 047	Continued From page 21 acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.  Actual NFPA Standard:  Reference: NFPA 101 (2000 edition)  19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.  7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the	K 047		3/1/2015	

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K 047	Continued From page 22 centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or	K 047		3/1/2015



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K 047	Continued From page 23 other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters. 7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5 Illumination of Signs. 7.10.5.1* General.	K 047		3/16/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  01/14/2015
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(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 047	Continued From page 24 Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high. Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5. 7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be	K 047		3/1/2015	

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K 047	<p>Continued From page 25</p> <p>of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator.</p> <p>7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5.</p> <p>7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5.</p> <p>Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other.</p>	K 047		3/1/2015

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K 047	Continued From page 26 Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system. NFFPA 101 LIFE SAFETY CODE STANDARD	K 047		3/1/2015	
K 064 SS=F	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFFPA 10  This STANDARD is not met as evidenced by: Based on fire extinguisher inspection record review and interview, it was determined the facility failed to maintain fire extinguishers in accordance with the National Fire Protection Association (NFFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).  The findings include:  Fire extinguisher inspection record review, on 01/14/15 at 9:10 AM, with the Maintenance Supervisor revealed the annual inspection for fire extinguishers was past due. The last inspection was conducted on 12/31/13.  Interview, on 01/14/15 at 9:11 AM, with the Maintenance Supervisor revealed he relied on the	K 064	K064 1. On 02/06/2015 the contract company conducted an annual inspection of all facility fire extinguishers. 2. On 02/06/2015 the contract company conducted an annual inspection of all facility fire extinguishers. 3. On 02/10/2015 the Administrator re-educated the maintenance director on the requirement for annual fire extinguisher inspection. 4. The Maintenance Director will audit all fire extinguishers monthly for three months. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly		

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K 084	<p>Continued From page 27</p> <p>contractor to keep up with inspecting the fire extinguishers</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 9.7.4 Manual Extinguishing Equipment 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>Reference: NFPA 10 Standard for Portable Fire Extinguishers</p> <p>6.1.2 The procedure for inspection and maintenance of fire extinguishers varies considerably. Minimal knowledge is necessary to perform a monthly "quick check" or inspection in order to follow the inspection procedure as outlined in Section 6.2. A trained person who has undergone the instructions necessary to reliably perform maintenance and has the manufacturer's service manual shall service the fire extinguishers not more than 1 year apart, as outlined in Section 6.3.</p> <p>6.2 Inspection. 6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and</p>	K 084		3/1/2015	

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K 064	Continued From page 28 thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or " hefting "  (6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (7) Pressure gauge reading or indicator in the operable range or position (8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (9) HMIS label in place 6.2.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 6.2.2, immediate corrective action shall be taken. 6.2.3.1 Rechargeable Fire Extinguishers. When an inspection of any rechargeable fire extinguisher reveals a deficiency in any of the conditions listed in 6.2.2(3), (4), (5), (6), (7), and (8), it shall be subjected to applicable maintenance procedures. 6.2.3.2 Nonrechargeable Dry Chemical Fire Extinguisher. When an inspection of any nonrechargeable dry chemical fire extinguisher reveals a deficiency in any of the conditions listed in 6.2.2(3), (5), (6), and (7), it shall be removed from further use, discharged, and destroyed at the direction of the owner or returned to the	K 064		2/11/2015	

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K 064	Continued From page 29 manufacturer. 6.2.3.3 Nonrechargeable Halon Agent Fire Extingulsher. When an inspection of any nonrechargeable fire extinguisher containing a halon agent reveals a deficiency in any of the conditions listed in 6.2.2(3), (5), (6), and (7), it shall be removed from service, not discharged, and returned to the manufacturer. If the fire extinguisher is not returned to the manufacturer, it shall be returned to a fire equipment dealer or distributor to permit recovery of the halon. 6.2.4 Inspection Recordkeeping. 6.2.4.1 Personnel making inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. 6.2.4.2 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. 6.2.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file or by an electronic method that provides a permanent record. 6.3* Maintenance. 6.3.1 Frequency. Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notificallon.	K 064		3/1/2015	
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2  This STANDARD is not met as evidenced by:	K 068			

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K 068	<p>Continued From page 30</p> <p>Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).</p> <p>The findings include:</p> <p>Observation, on 01/14/15 at 8:50 AM, with the Maintenance Supervisor revealed the attic access door located in the gas fired water heater room was missing, leaving the room open to the attic.</p> <p>Interview, on 01/14/15 at 8:51 AM, with the Maintenance Supervisor revealed he was not aware the attic door was missing.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the</p>	K 068	<ol style="list-style-type: none"> <li>1. The attic access door will be replaced by the maintenance director by 03/01/2015.</li> <li>2. There are no other rooms where , boiler, fuel fired HVAC or water heaters are installed. The attic access door will be replaced by the maintenance director by 03/01/2015.</li> <li>3. On 02/10/2015 the Administrator educated the maintenance director on the requirement for ventilation in the boiler room.</li> <li>4. The maintenance director will audit the boiler room monthly for three months to ensure the attic access door is in place. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly</li> </ol>	3/1/2015

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K 068	Continued From page 31 device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. NFPA 101 LIFE SAFETY CODE STANDARD	K 068		
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-seven (67) beds and at the time of the survey, the census was sixty-three (63).  The findings include:  Observation, on 01/14/15 at 11:00 AM, with the Maintenance Supervisor revealed a refrigerator and a coffee maker was plugged into a power strip located in the Business Office.  Interview, on 01/14/15 at 11:01 AM, with the	K 147	K0147  1. The power strip was removed from the Business Office on 02/09/2015 by the maintenance director. 2. On 02/06/2015 the maintenance director audited all areas to identify any power strips in use. 3. On 02/10/2015 the administrator educated the maintenance director on the requirement for power strips. 4. The maintenance director will conduct facility rounds to identify power strips in use weekly for four months then monthly x 2. The results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly for at least three months. If at any time concerns are identified the QAPI committee will convene to review and make further recommendations as needed. The	3/1/2015

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K 147	<p>Continued From page 32</p> <p>Maintenance Supervisor revealed he was aware of the requirements for the proper use of power strips; however he was not aware the power strip was being misused.</p> <p>The census of sixty-three (63) was verified by the Administrator on 01/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 01/14/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p>	K 147	<p>QAPI committee will consist of at a minimum the Administrator, Director of Nursing, Dietary Service Manager, Maintenance Director, Social Services Director with the Medical Director attending at least quarterly</p>	3/1/2015

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K 147	Continued From page 33  Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		3/1/2015	