

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

PRINTED: 12/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186364	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/05/2013
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  A Recertification Survey was conducted on 12/03/13 through 12/05/13 to determine the facility's compliance with Federal requirements. The facility met the minimum requirements for recertification with no deficiencies.	F 000			



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

*Angela R Head*

TITLE

*Administrator*

(X6) DATE

*12/29/2013*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 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 standard Life Safety Code survey was conducted on 12/04/13. Fordsville Nursing and Rehab Center 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-Two (62) 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>	1/10/14



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

*Amelia R. Head*

Administrator

12/29/2013

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 048 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1  This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure the fire safety plan included smoke compartment evacuation.  The findings include:  Fire Safety Plan review, on 12/04/13 at 12:00 PM with the Maintenance Supervisor, revealed the facility's Fire Safety Plan and Procedure Policy failed to address the evacuation of smoke compartments in the facility.  Interview, on 12/04/13 at 12:00 PM with the Maintenance Supervisor, revealed he was unaware the evacuation of smoke compartments	K 048		

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K 048	Continued From page 2 was not addressed on the fire safety plan as he has worked on the plan over the last nine (9) months.  Reference: NFPA 101 (2000 edition) Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be	K 048	K048 1. The Administrator will revise the fire evacuation policy and procedure to include evacuation from the smoke compartments by 1-9-2014. 2. The Administrator will revise the fire evacuation policy and procedure to include evacuation from the smoke compartments by 1-9-2014. 3. The Administrator will re-educate the Maintenance Director on the requirement that the fire safety plan include evacuation from smoke compartments by 1-9-2014. All facility staff will be re-educated on the fire evacuation plan to include evacuation from the smoke compartments by the Administrator or Maintenance Director by 1-9-2014. 4. The Administrator will review fire safety plan monthly for three (3) months to insure it includes evacuation of smoke compartments and present audits to the Quality Assurance Committee monthly for at least three (3) months or until the Quality Assurance Committee deems the deficient practice resolved. 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 and the Maintenance Director with the Medical Director attending at least Quarterly.	1/10/14

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K 048	Continued From page 3 instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy ' s fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extingulshment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest	K 048		

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K 048  K 064 SS=F	Continued From page 4 manual fire alarm box and NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure the fire extinguishers in the facility were being properly checked monthly.  The findings include:  Observation, on 12/04/13 at 12:40 PM with the Maintenance Supervisor, revealed the ABC fire extinguishers located at room #30 had no monthly checks for 2013, mechanical room no monthly checks for 2013, and the fire extinguisher at the smoking area in back had no monthly checks for 2013.  Interview, on 12/04/13 at 12:40 PM with the Maintenance Supervisor, revealed he was aware the fire extinguishers were supposed to be checked at 30 day intervals but had missed these three (3) on his rounds.	K 048  K 064	K064  1. On 12-20-2013, the Maintenance Director checked the ABC fire extinguishers located in room 30, the mechanical room and the smoke area and no concerns were identified.  2. On 12-20-2013, the Maintenance Director audited all ABC fire extinguishers in the facility to assure all had been checked timely with no concerns identified.  3. The Administrator will re-educate the Maintenance Director by 1-9-2014 on the requirement that all ABC fire extinguishers be checked monthly. By 1-9-2013, the Administrator will develop a monthly audit form identifying all ABC fire extinguishers in the facility to assure all are checked monthly. This audit form will be submitted to the Administrator monthly.  4. The Maintenance Director will complete the audit form of all ABC fire extinguishers monthly for at least three (3) months to the Quality Assurance Committee or until the Quality Assurance Committee deems the deficient practice resolved. 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 and the Maintenance Director with the Medical Director attending at least Quarterly.		

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K 064	Continued From page 5  Reference NFPA 10 (1998 Edition).  4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.  4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) *Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or " hefting " (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place	K 064		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:	K 066		

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K 066	Continued From page 6  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents that smoke, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty-Two (62) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into at the resident smoking area and the employee smoking area.	K 066	K066 1. The Maintenance Director will place self closing metal containers to dump ashes into at the resident smoking area and the staff smoking area. This will be completed by 1-9-2014. 2. By 1-9-2014, the Maintenance Director will audit all smoking areas to assure that all have self closing metal containers to dump ashes into. Any areas identified as not having these containers will have these containers placed by 1-9-2014. 3. The Administrator will re-educate the Maintenance Director on the requirement that all smoking areas have a self closing metal container to dump ashes into. This re-education will be completed by 1-9-2014. 4. The Maintenance Director will audit all smoking areas monthly for at least three (3) months to assure that all have a self closing metal container to dump ashes into. The results of these audits will be reviewed with the Quality Assurance Committee for at least three (3) months or until the Quality Assurance Committee deems the deficient practice resolved. 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 and the Maintenance Director with the Medical Director attending at least Quarterly.	1/10/14

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K 066	Continued From page 7  The findings include:  Observation, on 12/04/13 at 12:40 PM with the Maintenance Supervisor, revealed the smoking areas at the back residential smoking area and the employee smoking area did not have a metal container with a self-closing lid to dispose of the cigarette butts.  Interview, on 12/04/13 at 12:40 PM with the Maintenance Supervisor, revealed he was unaware of the requirement for a metal bucket with a self-closing lid at any smoking area.  Reference: NFPA Standard 101 (2000 Edition).  19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not	K 066		



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K 144	<p>Continued From page 9</p> <p>facility failed to ensure there was battery backup lighting at the generator transfer switch.</p> <p>The findings include:</p> <p>Observation, on 12/04/13 at 12:40 PM with the Maintenance Supervisor, revealed the facility did not have any battery-powered lighting installed in the room where the transfer switch for the emergency generator was located.</p> <p>Interview, on 12/04/13 at 12:40 PM with the Maintenance Supervisor, revealed he was not aware of the requirement for the battery backup lighting in the transfer switch room.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144	<ol style="list-style-type: none"> <li>1. A battery back up lighting system will be installed in the room for the transfer switch for the emergency generator by the Maintenance Director by 1-9-2014.</li> <li>2. A battery back up lighting system will be installed in the room for the transfer switch for the emergency generator by the Maintenance Director by 1-9-2014</li> <li>3. The Administrator will re-educate the Maintenance Director by 1-9-2014 on the requirement that there be a battery back up light in the room housing the emergency generator transfer switch.</li> <li>4. The Maintenance Director will audit the room housing the transfer switch monthly for at least three (3) months to assure that the battery operated back up lighting is effective. The results of these audits will be reviewed with the Quality Assurance Committee for at least three (3) months or until the Quality Assurance Committee deems the deficient practice resolved. 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 and the Maintenance Director with the Medical Director attending at least Quarterly.</li> </ol>	1/10/14