

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

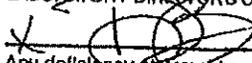
PRINTED: 03/14/2013
FORM APPROVED
OMB NO. 0938-0391

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 02/28/2013
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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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F 000	INITIAL COMMENTS A health recertification survey was initiated on 02/26/13 and concluded on 02/28/13 and a Life Safety Code survey was initiated and concluded on 02/27/13. Deficiencies were cited with the highest scope/severity being an "F", the facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	This plan of correction is submitted per requirement by State but does not constitute admission by the provider of any fact or conclusion set forth in this statement of deficiency.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	F 164 1. An observation of a skin assessment for resident # 10 was conducted by the Director of Nursing on 3/21/13 with no issues related to privacy and dignity observed. 2. An observation of resident	4/13/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3/22/2013
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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 disposable 60 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 disposable 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 164	<p>Continued From page 1 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure privacy and dignity for one (1) of sixteen (16) sampled residents during a skin assessment for Resident #10.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 02/28/13 at 2:00 PM, revealed the facility had no policy on resident dignity. Interview, on 02/28/13 at 4:30 PM, with the DON revealed privacy and dignity should be maintained at all times, and if a door should be opened he/she expected the resident to be covered or the curtain pulled.</p> <p>Observation of a skin assessment for Resident #10, on 02/28/13 at 8:40 AM, revealed Licensed Practical Nurse (LPN) #1 opened the hall door to talk with someone out in the hallway leaving Resident #10 exposed in full view of anyone in the hallway.</p> <p>Interview, on 02/28/13 at 3:00 PM, with Certified Nursing Assistant (CNA) #3 revealed when assessing a resident, the curtain should be pulled, the door closed, and areas that don't need to be exposed are covered.</p> <p>Interview with LPN #1, on 02/28/13 at 3:30 PM, revealed if someone knocked on the door, the staff should acknowledge and ask the person to wait a minute before the door is opened. She</p>	F 164	<p>care was completed by the Director of Nursing on 3/21/13 noted that there were no concerns with staff providing privacy and dignity.</p> <p>3. All Certified Nursing Assistants and Licensed staff will be re-educated by the Director of Nursing or Assistant Director of Nursing by 4/12/13 on resident privacy and dignity and complete a post test to validate competency.</p> <p>4. The Director of Nursing or The Assistant Director of Nursing will perform ten resident care observations weekly for four weeks and then five resident care observations for eight weeks to ensure privacy and dignity is observed. Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the</p>		

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IDENTIFICATION NUMBER:

186354

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY
COMPLETED

02/28/2013

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 164	Continued From page 2 stated she should have made sure Resident #10 was completely covered up before she opened the door.	F 164	Medical Director at least Quarterly on a monthly basis until the team concludes the issue is resolve. If at any time concerns are identified the Quality Assurance Committee Meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: Sharon Link Based on observation, interview, and record review, it was determined the facility failed to complete an activity assessment to identify a decline in function and ability to participate in activities for one (1) of the sixteen (16) sampled residents (Resident # 4) in order to develop a care plan to meet the resident's specific needs. The findings include: Interview with the Activity Director, on 02/28/13 at 2:00 PM, revealed the facility had no activity policies. Review of the clinical record for Resident #4 revealed the facility admitted the resident with diagnoses of Hypertension, Cerebral Vascular Disease, Dementia with Behavior Disturbance, Anxiety with Severe Psychotic Features, Depression, Convulsions, and Bipolar Disorder. Review of the Activity Director's notes, revealed the last activity assessment completed on the	F 248	F 248 1. An activity assessment for Resident #4 was completed By the Life Enrichment Director on 3/18/13 to reflect the the residents current Needs. 2. An audit of all resident Activity assessments was performed by the Life Enrichment Director on 3/18/13 with no other issues noted. All activity	4/13/13

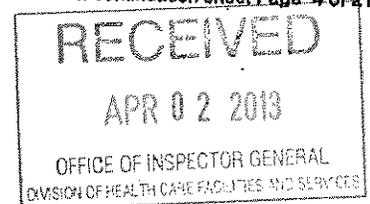
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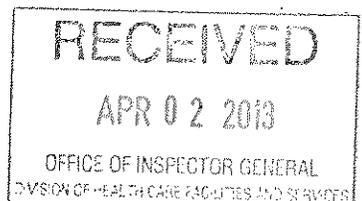
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F 248	<p>Continued From page 3 resident was dated 01/26/12.</p> <p>Interview with the Activity Director, on 02/27/13 at 10:55 AM, revealed she was aware Resident #4 had experienced a significant change in condition in January 2013. A significant change Minimum Data Set (MDS) assessment, dated, 01/17/13, was completed and reflected the resident's status related to nursing. A new activity assessment was not completed to reflect the resident's ability to participate in activities in the facility. The Activity Director stated she was in the process of updating the activity care plan for Resident #4; however, the care plan got erased from the computer when she attempted the update. She stated she had not replaced the activity care plan related to lack of time. She further explained that since the new company had taken over she thought she was not required to complete a new activity assessment annually, only if there was a significant change in condition in a resident. She stated there had been a significant change in the resident and an annual activity assessment should have been completed prior to completion of the significant change MDS; however, she had no explanation for not completing an annual assessment. Further interview with the Activity Director on, 02/28/13 at 1:30 PM, revealed Resident # 4 was more active in activities and left her room more prior to the significant change in condition. Resident #4 now stays in bed or room most of the time. The Activity Director revealed she had been trained on careplans by the previous owner of the facility.</p> <p>Interview with the Administrator, on 02/27/13, revealed he did not know for sure if there had been any policy changes related to how often</p>	F 248	<p>assessments are current and reflect resident needs.</p> <p>3. The Life Enrichment Director Was re-educated by the Administrator on 3/15/13 on ensuring resident activity assessments are completed on admission and with each OBRA assessment to reflect resident current needs. The Life Enrichment Director completed a post test to validate understanding and competency on 3/15/13.</p> <p>4. The Administrator or Director of Nursing will review resident activity assessments weekly for twelve weeks with each admission and OBRA assessment to ensure proper completion. Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the Medical Director at least Quarterly on a monthly basis until the team concludes the</p>		



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F 248	Continued From page 4 activity assessments were to be completed. He stated he would consult with the Regional Registered Nurse to see if any changes had been made in policy. On 02/28/13, the Administrator revealed per his conversation with the Regional Registered Nurse the forms sent in 06/12, for the Activity Director to use, were assessments with check boxes, and the Activity Director was no longer allowed to use the forms from the previous company. He stated as far as he knew there wasn't a policy on activity assessments.	F 248	issue is resolve. If at any time concerns are identified the Quality Assurance Committee Meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure staff labeled and stored resident equipment properly for eleven (11) of thirty-four (34) resident rooms (Rooms 3, 8, 14, 19, 21, 22, 29, 31, 34, 35 and 36) had urinals and wash basins placed on bathroom floors and unlabeled, soiled light cords, soiled paper signs, dead insects in overhead lights, a torn fall mat with a large tear and exposed foam, and a soiled box fan. The findings include: Interview with the Maintenance Director, on 02/28/13 at 1:30 PM, revealed there were no policies for the Maintenance Department.	F 253	F 253 1. On 3/20/13 the Housekeeping Supervisor replaced call cords In room 8-1, 8-2, and 22. The Housekeeping supervisor Cleaned the recliner in room 22, removed soiled paper Signs, and cleaned overhead Light covers in rooms 35 and 36. On 3/20/13 the Maintenance Director Removed the rust appearing Substance and rough edges from the door frame of room 19. On 3/21/13 the Administrator observed call cords in room 8-1, 8-2, and 22 were clean, the recliner was free of stains, and no paper signs were noted. On 3/21/13 the Administrator noted the	4/13/13	



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F 253 Continued From page 5

Interview with the Housekeeping Supervisor, on 02/28/13 at 1:50 PM, revealed there were no Housekeeping policies.

Interview with the Director of Nursing, on 02/28/13 at 2:00 PM, revealed there were no policies regarding residents having opened food containers in their rooms.

Interview with LPN #5, on 02/27/13 at 9:30 AM, revealed wash basins and bed pans must be labeled and covered before putting away, and should not be left on the bathroom floor.

Interview with the Director of Nursing, on 02/28/13 at 5:30 PM, revealed all urinals, wash basins, and fracture pans should be labeled and covered, and revealed charge nurses making rounds should be supervising the nurses aides to ensure this is being done.

1. Observations of the facility, on 02/26/13 at 11:15 AM, revealed Room 8-1 and 8-2 had light cords with brown stains from the middle to the ends. In addition, an upholstered recliner had dark stains on the seat and the armrests. The bathroom for Room 8 had soiled signs behind the commode and in the shower area and a soiled call light cord. In Rooms 35 and 36 there were dead insects in the overhead light cover. Room 19 had a rusty appearing door frame and rough sharp edges. Urinals were found located on the bathroom floor in Rooms 22, 29, 31 and 34. The urinals were not labeled with a room number and bed or with a resident name. Two wash basins and a fracture pan, lying in the bathroom floor of Room 14 on Fox's Drive. In addition, there was a

F 253

overhead light covers in rooms 35 and 36 were clean and no insects present, the door frame of room 19 was clean, free from rust and no rough edges were noted. On 3/20/13 the Director of Nursing, Assistant Director Of Nursing, and the Medical Records Nurse ensured all urinals, fracture pans, and wash basins were properly labeled with residents name, covered and stored. On 3/20/13 the House Keeping supervisor cleaned the fall mat in room 14-2 and the box fan blades in room 21. On 3/20/13 the Administrator provided chip Clips and Ziploc bags to the Resident in room 3 to place Open food bags in. On 3/21/13 during observation of room 3 by the Director of Nursing noted no open bags of potato chips, cookies, crackers, or candy. On 3/20/13 the Maintenance Director sanded The wood molding in room 13-1 to ensure it is smooth

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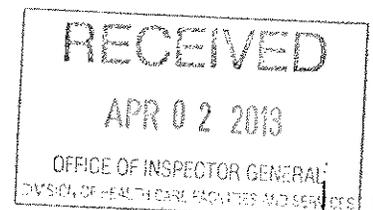
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F 253	<p>Continued From page 6</p> <p>urinal hanging over the trash can beside 14B. The wash basins were not labeled with a name or room number and bed number. In addition a fall mat by bed one had a large tear with the foam inside exposed. A box fan in Room 21 had blades covered in a black substance. Both residents in Room 22 had light cords soiled brown and there were two (2) soiled paper signs in the bathroom. There were bags and boxes of potato chips, cookies, crackers and candy opened in Room 3.</p> <p>Interview with the Maintenance Director, on 02/28/13 at 1:30 PM, revealed the facility staff completed a maintenance request form and placed it in a file when repairs were needed. He stated he picked up the requests daily and prioritized them. He stated no concerns were sent to him regarding the light cords. He stated he had a check off list to do preventative maintenance; however, there was no list for him to use to make rounds and identify problems otherwise. He stated there were no budget concerns and he could manage all the needs of the facility. He had no explanation for the problems found on tour. However, review of the preventative maintenance list revealed only items requiring preventative maintenance and not items that may potentially be identified as requiring maintenance, such as splintered wood, rusted door frames, etc.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 02/28/13 at 10:15 AM, revealed a maintenance form was filled out and placed in a bin when any repairs were needed. She stated there was no way to follow-up to ensure the needed repairs were completed.</p>	F 253	<p>With no splintered wood. An observation made by the Administrator on 3/21/13 noted the wood Molding in room 13-1 that Runs horizontally across the Room to be smooth and free Free from splintered wood.</p> <p>2. An observation made by the Administrator and the Director of nursing on 3/21/13 did not identify any urinals, fracture pans, or wash basins unlabeled or uncovered. All call cords were clean and free of debri, no soiled paper signs were noted, fall mats were clean and in good repair, all fans, recliners, and overhead light covers were clean and free of debri and no open bags of potato chips, cookies, crackers, or candy was noted. Wooden molding in all resident rooms were noted to be smooth and free of splintered wood.</p> <p>3. All certified nursing assistance will be re-educated by the Director of Nursing or</p>		

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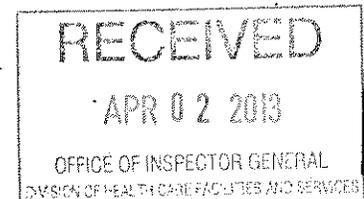
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F 253	Continued From page 7 Interview with Certified Nurse Aide (CNA) #2, on 02/28/13 at 2:10 PM, revealed resident urinals and wash basins were not to be stored on the floor. She stated they were to be stored in a plastic bag on the commode. She stated wash basins were stored covered in a drawer in the resident's room. She stated the items should have a room and bed number on them to prevent the wrong resident from using them and the floor could be dirty. Interview with CNA #3, on 02/28/13 at 2:15 PM, revealed urinals and wash basins were to be labeled, covered and stored. She stated the urinals and wash basins needed to be stored as the rooms were small and there was no room in the bath rooms. She stated it did not look home-like to have resident equipment stored on the floors. Interview with the Administrator, on 02/28/13 at 2:30 PM, revealed resident equipment needed to be stored properly and not on the floor. He stated a home-like environment was important to the residents. 2. Interview with the Director of Nursing, on 02/28/13 at 5:30 PM, revealed these issues have not been addressed recently with infection control. The DON stated she makes rounds to ensure things are being done, and has not had problems with lack of labeling before. Observation of Room 13A, on 02/26/13 at 11:20 AM, revealed a large wooden molding extending horizontally across the room, which had	F 253	Assistant Director of Nursing by 4/12/13 on labeling, covering, and storing urinals, fracture pans, and wash basins. All housekeeping staff will be re-educated by the Administrator by 4/13/13 on ensuring call cords, bedside mats, fans are clean during daily rounds. The Administrator will re-educate the Maintenance Director by 4/13/13 on ensuring wooden molding in resident rooms are smooth and free of splintered wood. All licensed staff will be re-educated by the Director of Nursing or Assistant Director of Nursing on ensuring all resident food items are properly sealed. 4. The Director of Nursing or the Assistant Director of Nursing will perform facility rounds three times a week for twelve weeks to ensure all urinals, fracture pans, and wash basins are properly labeled, covered, and stored, call cords, fans, bedside mats, recliners and overhead light	



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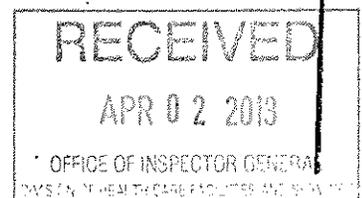
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F 263	Continued From page 8 splintered wood chips broken off. Interview with LPN #5, on 02/27/13 at 9:30 AM, revealed if any wood is chipped or environmental issues are noted, then a requisition is given to the Maintenance Department, so it can be fixed. The LPN stated one had not been completed. Observation, on 2/28/13 at 2:30 PM, revealed the wooden molding in Room 13A had not been fixed. Interview with the Maintenance Director, on 02/28/13 at 3:00 PM, revealed the splinters from the wooden molding in Room 13A had not been reported, and he had not received a requisition for this.	F 263	covers are clean and that paper signs are not soiled and resident food items are properly sealed. The Maintenance Director will perform weekly observations to ensure all wooden molding is smooth and free of splintered wood. Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the Medical Director at least Quarterly on a monthly basis until the team concludes the issue is resolve. If at any time concerns are identified the Quality Assurance Committee Meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272		4/13/13	



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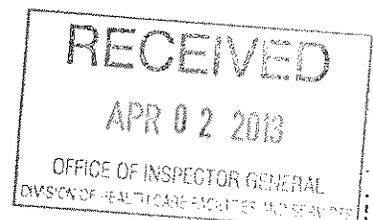
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
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F 272	<p>Continued From page 9 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, it was determined the facility failed to identify contractures in the Care Area Assessment (CAA) for pressure resulting in the failure to develop and implement interventions to prevent skin breakdown and other skin issues for one (1) of sixteen (16) sampled residents, Resident #10.</p> <p>The findings include: Interview, on 02/28/13 at 4:30 PM, with the DON revealed the facility did not have pillows available for prevention of skin breakdown.</p>	F 272	<p>F 272</p> <ol style="list-style-type: none"> 1. The Care plan for resident #10 was reviewed and updated by the Clinical Reimbursement Coordinator on 3/20/13 and risk factor for contractures was identified and care planned with appropriate goals and interventions in place. 2. An audit of all current resident care plans will be performed by the Director of Nursing, Assistant Director of Nursing, or the Clinical Reimbursement Coordinator by 4/18/13 to ensure risk factors are identified and care plan meets resident needs. Any identified concerns will be corrected. 3. The Regional Reimbursement Nurse will re-educate the MDS Nurse, Dietary Services Manager, Activity Director and the Social Services Director on the RAI process for CAA completion and Care Plan development and validate competency utilizing a post test by 4-18-2013. 4. The MDS Nurse will audit 		



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F 272	<p>Continued From page 10</p> <p>Observation of LPN #1 during a skin assessment for Resident #10, on 02/28/13 at 8:40 AM, revealed Resident #10's left arm was drawn up to his left shoulder and the LPN stated she need to contact the Therapy Department to stretch his/her arm out.</p> <p>Interview, on 02/28/13 at 8:40 AM, with LPN #1 revealed Resident #10 had redness to the inner left elbow with a yeasty smell. She stated it was from skin to skin contact and it measure 4.6 centimeters by 7.8 centimeters with no depth. The LPN assessed the area as a Stage 1 and the main thing was to keep the area clean, prevent ekin to skin contact and therapy needs to be contacted to stretch the arm out.</p> <p>Review of the clinical record for Resident #10 revealed the Minimum Data Set, dated 10/18/13, revealed the facility assessed the resident as totally dependent with bed mobility, was non-communicative and non-responsive, and was checked for contractures and functional limited range of motion.</p> <p>Review of the resident's careplans provided by the facility revealed Resident #10's Interventions consisted of lotion to the resident's limbs to sooth and calm, and consults as needed.</p> <p>Interview, on 02/28/13 at 3:00 PM, with Certified Nursing Assistant (CNA)#3 revealed she had not noticed the resident keeping his/her arm stiff.</p>	F 272	<p>three (3) comprehensive assessments per month for three (3) months to assure that the CAAs are worked correctly and that the risk factors are identified and the careplan meets the needs of the resident. Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing monthly for three months. The Medical Director will be in attendance at least quarterly. If at any time concerns are identified, Quality Assurance Committee Meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.</p>	



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F 272	Continued From page 11	F 272		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents (Resident #3) had a current physician's order for Do Not Resuscitate (DNR). The facility failed to ensure one (1) of sixteen (16) sampled residents received the correct tube feeding as ordered by the physician and the tube feeding bags were labeled appropriately. (Resident #10).</p> <p>The findings include:</p>	F 309	<p>F 309</p> <p>1. An order for code status was Obtained by the physician for Resident #3 on 3/1/13. A review of resident # 3 physician orders on 3/21/13 performed by the Director of Nursing revealed the order for code status was in place. On 2/28/13 the enternal feeding Noted as Glucerna 1.2 was Removed from the room of Resident #10 and replaced With Glucerna 1.5 and labeled by the Director of Nursing. An observation made by the Director of Nursing on 3/21/13 revealed the proper enternal feeding being administered to resident #10 and the enternal feeding bag was properly labeled with the correct enternal feeding.</p>	4/15/13

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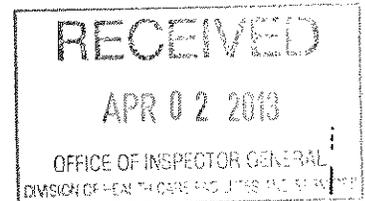
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F 309	<p>Continued From page 12</p> <p>Review of the facility's DNR policy, not dated, revealed the policy did not apply to the facility's staff. The policy addressed the implementation of a DNR in a pre-hospital setting by Emergency Medical Technicians and Paramedics.</p> <p>Interview with the Director of Nursing, on 02/28/13 at 2:30 PM, revealed the facility had no policy on physician orders; however, new order sheets were placed on charts monthly for physicians to sign.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident with diagnoses of Alzheimer's Disease and Cerebral Vascular Accident. The facility completed an annual Minimum Data Set (MDS) assessment on the resident on 12/18/12 which revealed the resident had a severe cognitive impairment and required total care with all needs. Review of the physician orders from January 2013 revealed there were no orders for a Code status. Review of the Advance Directive and a physician's order written in 2009 revealed the resident was a DNR.</p> <p>Interview with the Director of Nursing, on 02/28/13 at 2:30 PM, revealed physician's orders were renewed every 30 days. She stated the renewal orders needed to contain the DNR order and have a current physician signature. She stated she was not sure how the order was missed. She stated the facility had no policies on renewal orders or managing Advanced Directives.</p> <p>2. Review of the facility's policy regarding Enteral Nutrition Therapy, General Policy & Procedure, revealed it was the policy of the facility that</p>	F 309	<p>2. The Medical Records Nurse performed an audit of all resident physician orders on 3/20/13 to ensure the order for code status was in place with no issues noted. The Assistant Director of Nursing performed an observation of all <u>external feeding</u> to ensure proper feeding being administered and the external feeding bags were properly ordered with no issues noted.</p> <p>3. The Director of Nursing or Assistant Director of Nursing will provide re-education will be provided to all licensed staff by 4/12/13 on ensuring all physician orders contain an order for code status, correct labeling of enteral feeding bags and ensuring administration of ordered feeding and will validate Understanding and Competency with a post test.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, or the Medical Record Nurse will review ten resident</p>	

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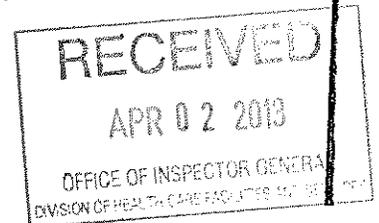
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F 309	<p>Continued From page 13</p> <p>residents admitted or re-admitted with nasogastric, gastrostomy or Jujostomy tubes would receive tube feedings as ordered by their physician. The polloy further stated Nursing Services would provide feeding as ordered: bolus feeding; closed delivery system; or own delivery system. The staff was to administer tube-feeding formula per physician's order.</p> <p>Review of the clinical record for Resident #10 revealed physician orders for Glucerna 1.5 at 45 cc/hr per tube for twenty-two hours and off two hours for activities of daily living.</p> <p>Observations, on 02/27/13 at 10:20 AM, in Resident 10's room revealed the enteral nutrition bag had a date of 02/27/13 and a time of 7:45 AM; but did not have the type of feeding documented on the label.</p> <p>Observation, on 02/28/13 at 8:20 AM, 8:40 AM, 9:00 AM, 10:10 AM, 11:00 AM, and 12:30 PM, in Resident #10's room revealed the enteral nutrition bag had Glucoerna noted on the label with no documentation of the type of Glucoerna.</p> <p>Observation and interview, on 02/28/13 at 4:00 PM, with the Director of Nursing (DON) revealed a Glucoerna 1.2 enteral nutrition bottle with the last name of Resident #10 on it, dated 02/28/13, sitting on the bedside table in Resident #10's room. The DON looked at the Glucoerna 1.2 enteral nutrition bottle and read the last name of Resident #10 on it and the date of 02/28/13.</p>	F 309	<p>physicans orders weekly for four weeks then monthly for three months to ensure an order for code status is in place. The Director of Nursing or the Assistant Director of Nursing will perform observations of all enteral feeding being administered three times a week for twelve weeks to ensure proper feeding being administered and proper labeling of all enternal feeding bags Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the Medical Director at least Quarterly on a monthly basis until the team concludes the issue is resolve. If at any time concerns are identified the Quality Assurance Committee Meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures</p>		



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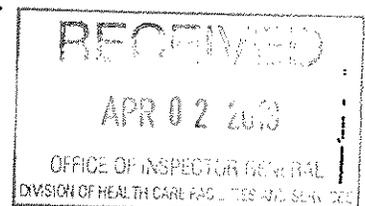
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F 309	Continued From page 14 The DON stated the physician order was for Glucerna 1.5, and on the resident's bedside table was Glucerna 1.2.	F 309	dependent upon the root cause to ensure on going compliance.	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - 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, record review, and review of the facility's policy, it was determined the facility failed to ensure sanitation of the dietary department as evidenced by an open box of plastic aprons stored in a large box beside the dish washing machine in contact with a large metal wrench used for the garbage disposal. In addition, four brown stained cloths were also in contact with the aprons. Above the open box and beside the area where the clean dishes exit the dish machine was a large heavily soiled, rusty appearing vent. The findings include: Review of the "Quick Kitchen Sanitation Rounds List", not dated and provided by the Dietary Manager on 02/18/13, revealed a section identified as Environment; floor is clean and	F 371	1. On 3/18/13 the Maintenance Director removed the wrench located in the dish room, the Dietary Manager removed the aprons and the table clothes, and the House Keeping supervisor cleaned the vent above the clean dish exit. An observation of the dish room by the Administrator on 3/21/13 revealed the vent located above the clean dish exit to be clean with no dust or rust present. The Administrator also noted on 3/21/13 there were no wrenches, aprons, or table clothes present. 2. An observation by the Administrator on 3/21/13 of the dish room did not identify any sanitation issues. 3. All dietary staff will be re-educated by the Dietary Manager on ensuring the dish room is sanitary and the vent above the clean dish exit is	4/13/13



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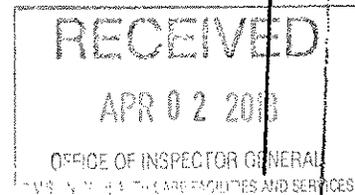
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F 371	<p>Continued From page 15 without buildup; walls and the ceiling are without holes and damage; and equipment is clean and in working order.</p> <p>In addition, review of the Maintenance Schedule titled TASKS for February, not dated and provided by the Maintenance Director on 02/28/13, revealed a check list for Exhaust Fans: Inspect exhaust fans for proper operation and clean if necessary.</p> <p>Observation of the dish room, on Initial tour, on 02/26/13 at 11:10 AM, revealed an open card board box containing four boxes of plastic aprons. Lying on top of the plastic aprons was a large metal instrument. Also observed, lying on top of the aprons, were four brown stained cloths, which did not appear to be clean. In addition, a large dirty vent, which appeared to be covered in rust, was observed above the box, and the area where clean dishes exit the dish machine.</p> <p>Interview with the Dietary Manager (DM), on 02/28/13 at 1:50 PM, revealed the metal tool found in the box was used to unclog the garbage disposal in the sink adjacent to the dish machine when needed. The DM stated the wrench should not have been stored in the box with the plastic aprons, and stated she thought the four (4) stained clothes were clean, but was used for wiping down the dish room walls. The DM stated they should not be stored there.</p> <p>Further Interview with the Dietary Manager, on 02/28/13 at 1:50 PM, revealed Housekeeping/Maintenance Department was responsible for cleaning the vent once a month, and stated the potential of dirty vents could cause</p>	F 371	<p>free of dust or rust by 4/12/13.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or the Medical Records nurse will audit five employee tuberculin skin test records weekly for twelve weeks to ensure annual skin tests are administered on or before the anniversary date of the last skin test. Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the Medical Director at least Quarterly on a monthly basis until the team concludes the issue is resolve. If at any time concerns are identified Quality Assurance Committee Meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.</p>	



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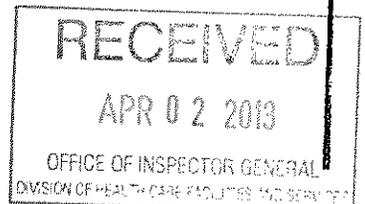
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F 371	Continued From page 16 dirt to fall onto the clean dishes.	F 371		
F 441 SS=E	483.66 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		4/13/13



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F 441	<p>Continued From page 17</p> <p>Isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation interview and facility policy review, it was determined the facility failed to maintain an infection control program to ensure three (3) of five (5) sampled medication carts were clean. The facility failed to maintain an infection control program to ensure residents' equipment was stored to prevent cross-contamination.</p> <p>The findings include: Interview with the Director of Nursing, on 02/28/13 at 5:30 PM, revealed all urinals, wash basins, and fracture pans should be labeled and covered, the Urinal should not be hanging over the trash can, and revealed charge nurses making rounds should be supervising the nurses aides to ensure this was being done.</p>	F 441	<p>F 441</p> <ol style="list-style-type: none"> On 3/20/13 the Director of Nursing, Assistant Director Of Nursing, and the Medical Records Nurse ensured all urinals, fracture pans, and wash basins were properly labeled with residents name, covered and stored, cleaned all medication carts and replaced all pill crushers. An observation made by the Director of nursing on 3/21/13 did not identify any urinals, fracture pans, or wash basins unlabeled or uncovered. All medication carts were noted to be clean on 3/21/13 by the Director of Nursing. All certified nursing assistance will be re-educated by the Director of Nursing or Assistant Director of Nursing by 4/2/13 on labeling, covering, and storing urinals, fracture pans, and wash basins. All licensed staff will be re-educated by the Director of Nursing or the Assistant 		



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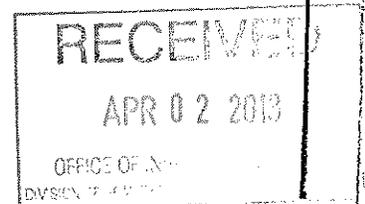
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NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
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F 441	Continued From page 18 Interview with the Director of Nursing, on 02/28/13 at 2:30 PM, revealed there were no other facility policies addressing infection control. She stated there were no facility policies for cleaning the medication carts. 1. Observations of the facility, on 02/26/13 at 11:15 AM, revealed Room 8-1 and 8-2 had white light cords with brown stains from the middle to the ends. In addition an upholstered recliner had dark stains on the seat and the armrests. Room 8's bathroom had soiled paper signs taped to the wall behind the commode and in the shower area and a soiled white call light cord. Resident urinals were found on the bathroom floors in Rooms 22, 29, 31 and 34. The urinals were not labeled with a room number and bed or with a resident name. Two wash basins and a fracture pan lying in the bathroom floor of Room 14 on Fox's Drive. In addition, there was a urinal hanging over the trash can beside the bed in 4B. The wash basins were not labeled with a name or room number and bed number. In addition a fall mat by bed one had a large tear with the foam inside exposed. A box fan in Room 21 had blades covered in a black substance. Room 22 Bed-1 and Bed-2 had white light cords which were soiled brown and there were (2) soiled paper signs in the bathroom. 2. Observation of two medication carts on Harmony Way, on 02/27/13 at 8:15 AM, revealed Cart #1 was soiled on the outside with a brown build-up around the inside edges of the top. The drawer labels were white with black discoloration around the edges. The attached sharps container had smears of tan and brown on the outside. The pill crusher was heavily soiled with a	F 441	Director of Nursing by 4/12/13 on ensuring medication carts are clean. All licensed staff will complete a post test to validate competency by 4/12/13. 4. The Director of Nursing or the Assistant Director of Nursing will perform facility rounds three times a week for four weeks and the weekly for eight weeks to ensure all urinals, fracture pans, and wash basins are properly labeled, covered, and stored and that medication carts are clean. Results will be reviewed by the Quality Assurance Committee Consisting of the Director of Nursing, Administrator, Social Service Director, Assistant Director of Nursing and the Medical Director at least Quarterly on a monthly basis until the team concludes the issue is resolve. If at any time concerns are identified the Quality Assurance Committee Meeting will be called by the Administrator or Director of		

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DIVISION OF HEALTH SERVICES REGULATION

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

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FORM APPROVED
OMB NO. 0938-0391

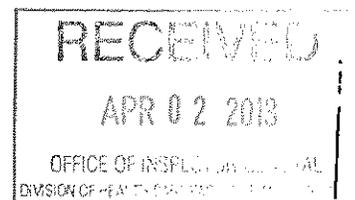
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2013
NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, 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 441	<p>Continued From page 19 black and brown build-up all around the edges. Cart #2 was soiled on the outside and the drawer labels were discolored as with Cart #1. The pill crusher had a build-up of a black substance. There were brown particles inside the bottom drawer.</p> <p>Observations of a medication cart on Fox Drive, on 02/28/13 at 11:05 AM, revealed the drawers on the cart were labeled and soiled with a black substance. The pill crusher had a tan colored sticky substance around the edges. The top of the cart had a tan build-up around the inside edges of the cart.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 02/28/13 at 9:15 AM, revealed resident equipment was not stored on the floors as it was an infection problem and infections could spread. She stated urinals, bedpans and wash basins were supposed to be covered and stored.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 02/28/13 10:15 AM, revealed the night shift was responsible to clean the medication cart and each nurse wiped down the carts at the end of their shift. She stated the pill crushers were cleaned weekly by the kitchen using the dish washer. She stated urinals and bed pans and wash basins were labeled with the residents' room number and bed number. She stated resident equipment was not stored on the floor to prevent the spread of infection. She stated she supervised the aides and had not noticed any equipment in the rooms on the floor.</p> <p>Interview with LPN #5, on 02/27/13 at 9:30 AM, revealed wash basins and bed pans must be</p>	F 441	Nursing to analyze and implement further measures dependent upon the root cause to ensure on going compliance.	



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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 02/28/2013
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)	(X6) COMPLETION DATE	
F 441	Continued From page 20 labeled and covered before putting away, and should not be left on the bathroom floor. Interview with the Maintenance Director, on 02/28/13 at 1:30 PM, revealed the light cords were soiled and needed to be replaced. He stated he was not sure what the stains were; however, they did not look good and could be something that had germs causing an infection. Continued interview with the DON, on 02/28/13, revealed the issues identified had not been addressed in Infection Control; however, these things were Infection Control problems.	F 441			



From:

04/01/2013 15:56

#221 P.027/055

From:

03/26/2013 13:33

#211 P.029/081

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: 185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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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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(K4) 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 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

BUILDING: 01.

PLAN APPROVAL: 1885.

SURVEY UNDER: 2000 Existing.

FACILITY TYPE: SNF/INF.

TYPE OF STRUCTURE: One (1) story, Type III (200).

SMOKE COMPARTMENTS: Four (4) smoke compartments.

FIREALARM: Complete fire alarm system installed in 1965, upgraded in 2010 with 20 smoke detectors and 1 heat detectors.

SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1965, and upgraded in 2009.

GENERATOR: Type II generator installed in 2010. Fuel source is LP.

A standard Life Safety Code survey was conducted on 02/27/13. 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 (60) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal

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

TITLE

(X6) DATE

[Signature] Administrator 3/22/2013

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.

If continuation sheet Page 1 of 29

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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From:

04/01/2013 15:56

#221 P.028/055

From:

03/26/2013 13:34

#211 P.030/081

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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 02/27/2013
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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 Continued From page 1
Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 000

Deficiencies were cited with the highest deficiency identified at "F" level.

K 018 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

K 018

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.8.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty-two (52) residents,

1. Maintenance Director will repair corridor doors to rooms 24, 11, 12 and 14 so they will latch properly by 04/12/2013. Maintenance Director will repair doors 27 and 29 where there is no gap above the doors by 04/12/2013. Doors 24, 4, 11 and 12 will be repaired to where there are no gaps larger than 1/2 inch by 04/12/2013.
2. Maintenance Director will perform observations on all other corridor doors to rooms to ensure they latch properly, there are no gaps at the top of doors and that there are no other gaps larger than 1/2 inch around the door jambs and address any issues identified by 04/12/2013.
3. Maintenance Director was educated on 03/20/2013 using referenced NFPA Life Safety Code regulation.

4/13/13

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From:

04/01/2013 15:57

#221 P.029/055

From:

03/26/2013 13:34

#211 P.031/081

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: 185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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)
K 018	<p>Continued From page 2</p> <p>staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure four (4) corridor doors to the resident rooms were latching properly and six (6) doors that had too large of a gap around the door jamb.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Observations, on 02/27/13 between 1:40 PM and 3:30 PM, with the Maintenance Director revealed the corridor doors to rooms 24, 11, 12, and 14 would not latch properly. Interview, on 02/27/13 between 1:40 PM and 3:30 PM, with the Maintenance Director revealed he was unaware the doors listed would not latch properly. Observations, on 02/27/13 between 1:40 PM and 3:30 PM, with the Maintenance Director revealed the corridor doors to rooms 27 and 29 had a gap at the top of the door. Further observation revealed rooms #24, 4, 11, and 12 had a gap larger than 1/8 inch around the door jamb. Interview, on 02/27/13 between 1:40 PM and 3:30 PM, with the Maintenance Director revealed he was unaware of the unacceptable gap around the doors. <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be</p>	K 018	<p>4. Maintenance Director will perform observations once a month for three months to ensure no other issues identified with corridor doors to resident rooms. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.</p>

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From:

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#221 P.030/055

From:

03/26/2013 13:34

#211 P.032/081

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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

K 018 Continued From page 3
substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.6 cm) shall be permitted for corridor doors.
Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.
Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.6.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

K 018:

19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 025:

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may

4/13/13

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04/01/2013 15:57

#221 P.031/055

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03/26/2013 13:34

#211 P.033/081

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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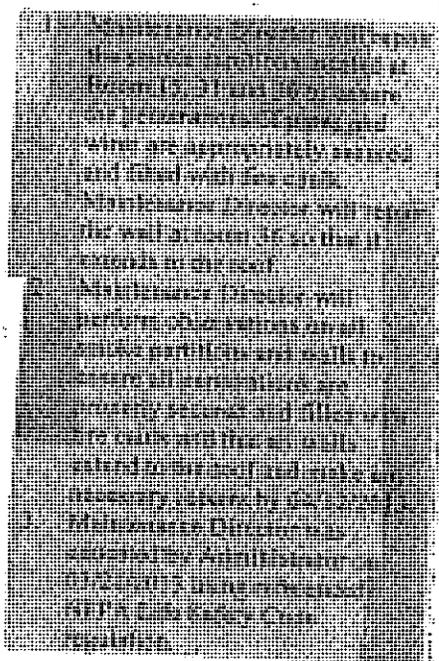
NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343
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K 025 Continued From page 4

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

K 025



This STANDARD is not met as evidenced by: Based on observations 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 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 (60) on the day of the survey. The facility failed to ensure three (3) smoke barriers were sealed and extended to the roof decking to resist the passage of smoke.

The findings include:

Observations, on 02/27/13 between 11:00 AM and 12:00 PM, with the Maintenance Director revealed the smoke partitions, extending above the ceiling located at room #15, 31, and 38 were penetrated by pipes and wires. Further observation revealed the wall at room #36 did not extend to the roof.

Interview, on 02/27/13 between 11:00 AM and 12:00 PM, with the Maintenance Director

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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 02/27/2013
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NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 319 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 025 Continued From page 5
revealed he was unaware of the penetrations in the smoke barriers.

K 026

Reference: NFPA 101 (2000 Edition).

8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:

(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.

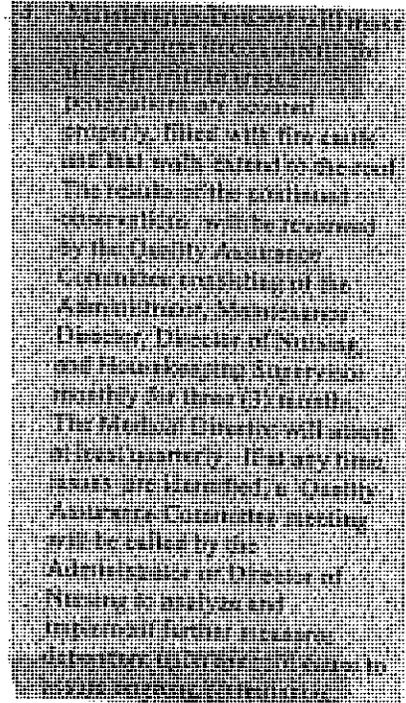
(c) Where designs take transmission of vibration into consideration, any vibration isolation shall

1. Be made on either side of the smoke barrier, or
2. Be made by an approved device designed for the specific purpose.

8.3.8.2 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



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From:

04/01/2013 15:58

#221 P.033/055

From:

03/26/2013 13:35

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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 02/27/2013
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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 025 Continued From page 6 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 026

K 027 SS=P NFPA 101 LIFE SAFETY CODE STANDARD
Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-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

K 027

1. Maintenance Director will repair cross corridor doors located at Room 37 will close completely leaving a gap of less than 1/8 of an inch and cross corridor doors at Room 15 will be equipped with a door coordinator by 04/12/2013.
2. Maintenance Director will make observations on all cross corridor doors to ensure they will close completely leaving less than a gap of 1/8 of an inch and all cross corridor doors have door coordinator by 04/12/2013.
3. Maintenance Director was educated by Administrator on 03/21/2013 using referenced NFPA Life Safety Code regulation.

4/13/13

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 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 (60) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly with a door coordinator and ensure the proper gap in a cross-corridor door.

The findings include:

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From:

04/01/2013 15:59

#221 P.034/055

From:

03/26/2013 13:35

#211 P.036/081

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

PRINTED: 03/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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
K 027	Continued From page 7 Observation, on 02/27/13 at 1:17 PM, with the Maintenance Director revealed the cross-corridor doors located at room #37 would not close completely leaving a gap over 1/8 of an inch. Further observation revealed the cross-corridor doors at room #15 was not equipped with a door coordinator. Interview, on 02/27/13 at 1:17 PM, with the Maintenance Director revealed the coordinator on the doors at room #15 was removed because the ceiling was not letting it function properly. Further interview revealed he was unaware of the proper gap in the cross-corridor 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 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. NFPA 101 LIFE SAFETY CODE STANDARD SS=D One hour fire rated construction (with 1/4 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 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	K 027	4. Maintenance Director will make observations once a month for three months to ensure cross corridor doors will close completely leaving a gap of less than 1/8 of an inch and cross corridor doors at Room 15 will have door coordinators on them. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.	4/13/13

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From:

04/01/2013 15:59

#221 P.035/055

From:

03/26/2013 13:36

#211 P.037/081

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

PRINTED: 03/11/2013
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 02/27/2013
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 029 Continued From page 8 permitted. 19.3.2.1

K 029

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure two (2) rooms were properly protected due to the storage in the rooms.

The findings include:

Observation, on 02/27/13 at 3:30 PM, with the Maintenance Director revealed the medical records office and the activities office did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas.

Interview, on 02/27/13 at 3:30 PM, with the Maintenance Director revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.

Reference: NFPA 101 (2000 Edition).

19.3.2 Protection from Hazards.

19.3.2.1 Hazardous Areas. Any hazardous areas

1. Maintenance Director will have door closers added to the medical records and activities office by 04/12/2013.
2. Maintenance Director will make observations and ensure no other areas that would require a self door closer by 04/12/2013.
3. Maintenance Director was educated by the Administrator on 03/27/2013 using referenced NFPA Life Safety Code regulation.

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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 02/27/2013
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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 029 Continued From page 9
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 ft² (9.3 m²)
(3) Paint shops
(4) Repair shops
(5) Soiled linen rooms
(6) Trash collection rooms
(7) Rooms or spaces larger than 50 ft² (4.6 m²), 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.
NFPA 101 LIFE SAFETY CODE STANDARD

K 029

4. Maintenance Director will make observations once a month for three months to ensure no other areas would require a self door closer. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance

K 038
66=E
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

K 038

Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.

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From:

04/01/2013 16:00

#221 P.037/055

From:

03/26/2013 13:36

#211 P.039/081

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K 038 Continued From page 10

K 038.

1. Maintenance Director will ensure the rear exit to the Foxe's Drive Corridor will have a 4 foot wide durable surface to a public way by securing a contract to lay 4 foot sidewalk from the Foxe's Drive corridor to the parking lot. The contract will be secured by 04/12/2013 and the sidewalk will be constructed when weather permits. Maintenance Director will ensure egress doors within the facility are equipped with 15 second delayed egress doors signage by 04/12/2013.
2. Maintenance Director will make observations and ensure that the contract for the 4 foot wide durable surface will extend to a public way and that all egress

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure one (1) exit had a durable surface to the public way and delayed egress signage was applied to the exit doors.

The findings include:

1. Observation, on 02/27/13 at 2:45 PM, with the Maintenance Director revealed the rear exit to the Fox's Drive corridor did not have a 4 foot wide durable surface to a public way.

Interview, on 02/27/13 at 2:46 PM, with the Maintenance Director revealed he was unaware exits require a durable path to the public way.

2. Observation, on 02/27/13 at 3:10 PM, with the Maintenance Director revealed egress doors in the facility were equipped with 15 second delayed egress doors with no signage posted on the doors.

Interview, on 02/27/13 at 3:10 PM, with the

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K 038 Continued From page 11
Maintenance Director revealed he was unaware the doors were required to have delayed egress signage applied to the door if there was a delay on the door opening.

K 038

- 3. Maintenance Director was educated by Administrator on 03/21/2013, using referenced Life Safety Code regulation.
- 4. Maintenance Director will make observations once a month for three months to ensure all egress doors in the facility have required 15 second delayed signage posted on them and monitor installation of 4 foot durable surface to a public way. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least if at any

Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way.
7.7.1.

Reference: NFPA 101 (2000 edition)
7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.
7.6.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.
7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.
Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.
Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.
Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22

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From:

04/01/2013 16:01

#221 P.039/055

From:

03/26/2013 13:37

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K 038	Continued From page 12 and 23. CMS S&C letter 5-38 Reference: NFPA 101 (2000 Edition) 19.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.6.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section	K 038	time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.

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From:

04/01/2013 16:01

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From:

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K 038 Continued From page 13
9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

K 038

K 047 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
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

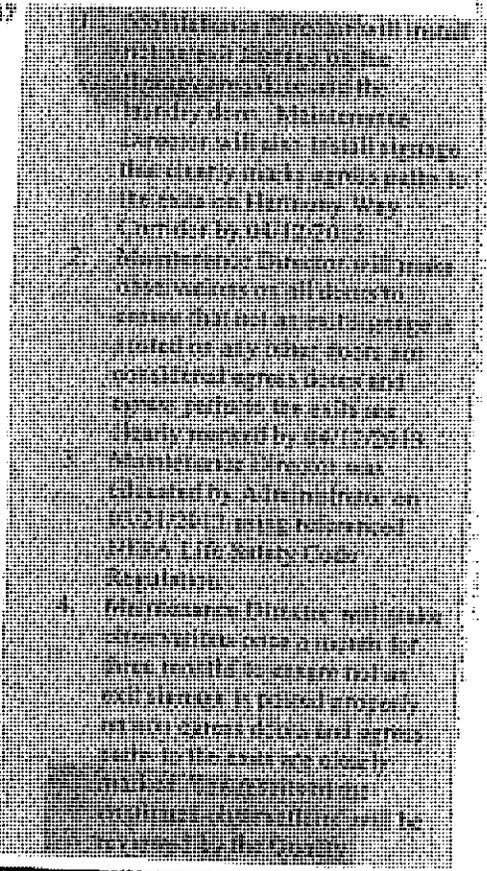
K 047

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure no exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (1) of four (4) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure two (2) doors leading to the outside were marked with proper no exit signs.

The findings include.

1. Observation, on 02/27/13 at 1:04 PM, with the Maintenance Director revealed doors leading to the outside of the facility with no signage on the doors that were not exits. The therapy area door and the laundry door were the doors without the proper signage on them

Interview, on 02/27/13 at 1:04 PM, with the Maintenance Director revealed he was unaware



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K 047 Continued From page 14
doors must be marked with no exit signage if they are not being used as an exit.

K 047

2. Observation, on 02/27/13 at 3:45 PM, with the Maintenance Director revealed egress paths to the exits was not clearly marked in the Harmony Way Corridor.

Interview, on 02/27/13 at 3:45 PM, with the Maintenance Director revealed he was unaware the signage was missing for the exits.

Reference: NFPA 101 (2000 edition)

7.10.8 Special Signs.

7.10.8.1* No Exit.

Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:

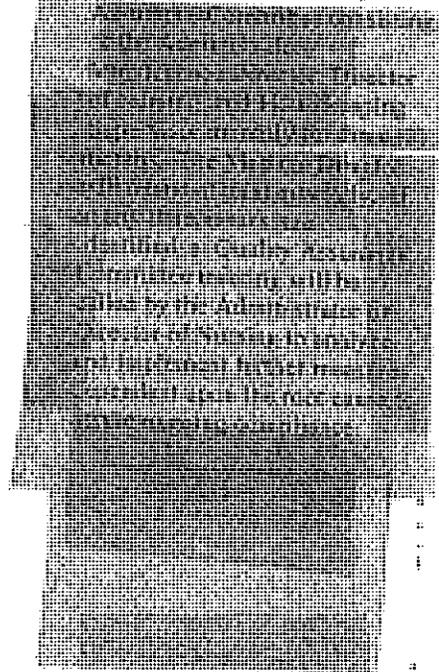
NO
EXIT

Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.

Exception: This requirement shall not apply to approved existing signage.

Reference: NFPA 101 (2000 edition)

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



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From:

04/01/2013 16:02

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From:

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K 047 Continued From page 15
any direction
of exit access.

K 047

K 048 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 048

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

1. Maintenance Director will revise Fire Evacuation Policy that directs the therapy area to an appropriate evacuation exit and correctly label smoke compartments in the facility by 04/12/2013.

4/13/13

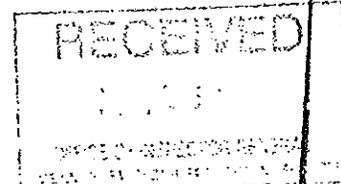
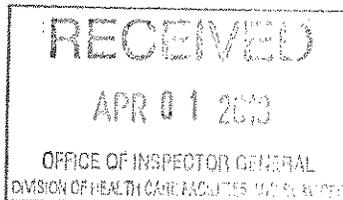
This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect 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 (60) on the day of the survey. The facility failed to ensure smoke compartments were clearly identified and the therapy area was exiting the correct way in the fire safety plan.

- 2. Maintenance Director will make observations of the Fire Evacuation Policy to ensure all directed evacuation routes are those to exits and that all smoke compartments are correctly labeled by 04/12/2013.
- 3. Maintenance Director was educated by Administrator on 03/21/2013 using referenced Life Safety Code regulation.
- 4. Maintenance Director will make observations once a month for three months to ensure the Fire Evacuation Policy directs to exits and smoke compartments are correctly labeled. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator,

The findings include:

Policy review, on 02/27/13 at 11:00 AM, with the Maintenance Director revealed the facility's Fire Safety Plan and Procedure Policy directed the therapy area to exit through a door that was not being used as an exit. Further review revealed the facility did not have the smoke compartments correctly labeled at the facility.

Interview, on 02/27/13 at 11:00 AM, with the Maintenance Director revealed he was unaware the smoke compartments were not correctly



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K 048 Continued From page 18
Identified and the evacuation route for the therapy area was labeled incorrectly.

Actual NFPA Standard: 19.7.1 Evacuation and Re-coalition Plan and Fire Drills.
19.7.1.1

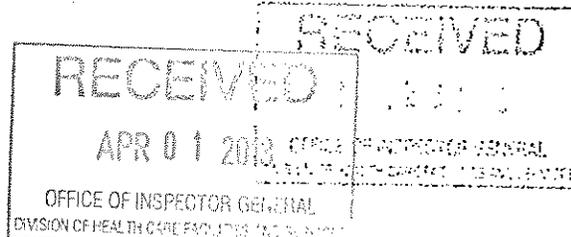
The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees 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 instructed in life safety procedures and devices.

K 048 Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.



From:

04/01/2013 16:03

#221 P.044/055

From:

03/26/2013 13:38

#211 P.046/081

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

PRINTED: 03/11/2013
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188364	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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
K 048	Continued From page 17 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) Extinguishment 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2013
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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 02/27/2013
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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 048 Continued From page 18
manual fire alarm box and

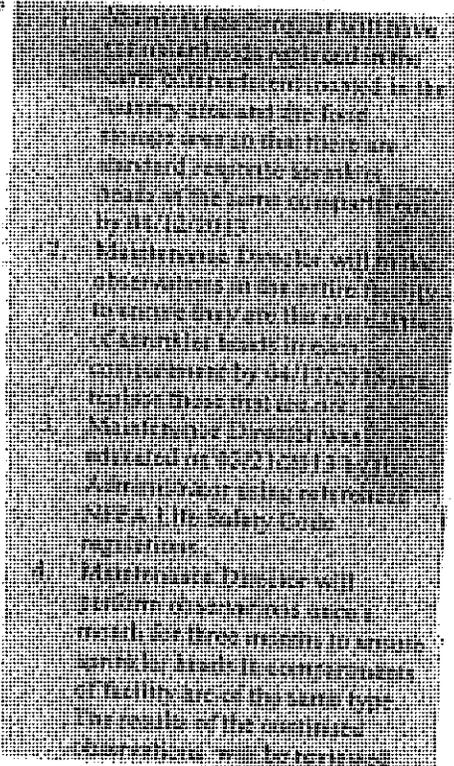
K 066 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

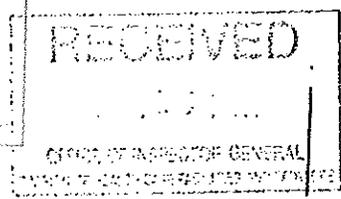
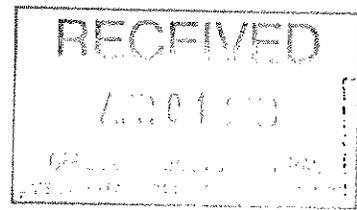
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure all sprinkler heads in the same compartment would or page at the same heat level.

The findings include:

Observations, on 02/27/13 at 2:38 PM, with the Maintenance Director revealed standard



4/13/13



From:

04/01/2013 16:03

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From:

03/26/2013 13:39

#211 P.048/081

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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 02/27/2013
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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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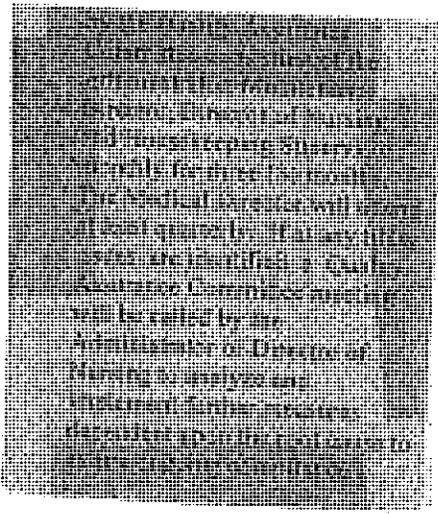
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 056 Continued From page 19
response sprinkler heads and quick response sprinkler heads in the same compartment located in the laundry area and the food storage area.

K 056

Interview, on 02/27/13 at 2:36 PM, with the Maintenance Director revealed he was not aware these two areas did not have proper sprinkler protection. He had a contractor check for this issue and these two areas must have been missed on the walkthrough.

Reference: NFPA 13 (1999 Edition)
7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system, or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:
(1) Wet pipe system
(2) Light hazard or ordinary hazard occupancy
(3) 20-ft (6.1-m) maximum ceiling height
The number of sprinklers in the ceiling area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the proposed reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use



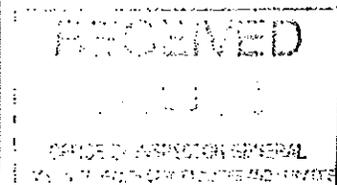
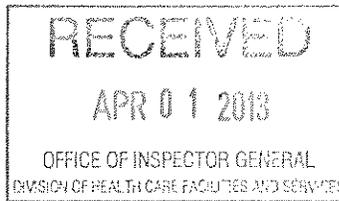
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OMB NO. 0938-0391

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 02/27/2013
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 068	Continued From page 20 of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056		
K 082 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system 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 (60) on the day of the survey. The facility failed to ensure the inside of the sprinkler piping and the gauges on the sprinkler riser were inspected every five (5) years. The findings include: 1. Observation and record review, on 02/27/13 at 2:15 PM, with the Maintenance Director revealed the facility failed to provide documentation that the gauges on the sprinkler riser had been calibrated or replaced within the last 5 years. Interview, on 02/27/13 at 2:15 PM, with the	K 082	1. Maintenance Director will have the gauges on the sprinkler riser inspected for calibration needed; replacement and an internal inspection performed by 04/12/2013 and obtain proper record for documentation of. 2. Maintenance Director will make observations of documentation provided to ensure it addresses calibration issues if any, replacement if needed and internal inspection with results by 04/12/2013. 3. Maintenance Director was educated by Administrator on 03/21/2013 using referenced NFPA Life Safety Code regulation. 4. Maintenance Director will observe documentation once a month for three months to ensure that all	4/13/13



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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 062 Continued From page 21

Maintenance Director revealed he was not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years.

2. Observation and records review, on 02/27/13 at 3:05 PM, with the Maintenance Director revealed the sprinkler system had no internal inspection within the last 5 years. Further observation showed the last internal pipe inspection was performed in 2007.

Interview, on 02/27, 13 at 3:05 PM, with the Maintenance Director revealed he was aware the internal pipe inspection was to be performed every five (5) years but he was unaware the last inspection was over five (5) years ago.

Reference: NFPA 25 (1998 Edition),

10-2.2* Obstruction Prevention.
Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 8 years. This investigation shall be accomplished by examining the interior of a c / valve or preaction valve and by removing two cross main flushing connections.

10-2.3* Flushing procedure.
If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted.

K 062

issues related to sprinkler riser inspections, calibrations, replacements have been addressed. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.

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From:

04/01/2013 16:04

#221 P.049/055

From:

03/26/2013 13:40

#211 P.051/081

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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 02/27/2013
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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 062 Continued From page 22
The work shall be done by qualified personnel.

K 062

Reference: NFPA 25 (1998 Edition).

2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.

Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.

Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Items Activity Frequency Reference
Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2
Control valves Inspection Weekly/monthly Table 2-1
Alarm devices Inspection Quarterly 2-2.6
Gauges (wet pipe systems) Inspection Monthly 2-2.4.1
Hydraulic remote inspection Quarterly 2-2.7
Buildings Inspection Annually (prior to freezing weather) 2-2.5
Hanger/seismic bracing Inspection Annually 2-2.3
Pipe and fittings Inspection Annually 2-2.2
Sprinklers Inspection Annually 2-2.1.1
Spare sprinklers Inspection Annually 2-2.1.3
Fire department connections Inspection Table 9-1
Valves (all types) Inspection Table 9-1

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From:

04/01/2013 16:05

#221 P.050/055

From:

03/26/2013 13:40

#211 P.052/081

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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 CODE AND IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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K 062 Continued From page 23
Alarm devices Test Quarterly 2-3.3
Main drain Test Annually Table G-1
Antifreeze solution Test Annually 2-3.4
Gauges Test 5 years 2-3.2
Sprinklers - extra-high temp. Test 5 years 2-3.1.1
Exception No. 3
Sprinklers - fast response Test At 20 years and every 10 years thereafter
2-3.1.1 Exception No. 2
Sprinklers Test At 50 years and every 10 years thereafter
2-3.1.1
Valves (all types) Maintenance Annually or as needed Table G-1
Obstruction investigation Maintenance 5 years or as needed Chapter '0

K 073 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to 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 (37) beds with a census of Sixty (30) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated.

The findings include:

1. Maintenance Director will use flame retardant for stuffed animals, wreaths, and artificial floral arrangements throughout the facility and have documentation of such.

2. Maintenance Director and Housekeeping Supervisor will make observations within the facility and ensure stuffed animals, wreaths and artificial floral arrangements have flame retardant applied and have documentation of those items by 04/12/2013.

4/13/13

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From:

04/01/2013 16:05

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From:

03/26/2013 13:41

#211 P.053/081

DEPARTMENT OF HEALTH AND HUMAN 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 02/27/2013
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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)	(X6) COMPLETION DATE
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K 073	<p>Continued From page 24</p> <p>Observation, on 02/27/13 at 3:05 PM, with the Maintenance Director revealed several stuffed animals, wreaths, and artificial floral arrangements throughout the facility had no documentation of flame retardant being applied.</p> <p>Interview, on 02/27/13 at 3:08 PM, with the Maintenance Director revealed he was aware decorations were required to be treated with a fire retardant spray but he did not have any documentation showing items were being properly treated.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p>	K 073	<p>3. Maintenance Director was educated on 03/21/2013 by Administrator on keeping records of items that have had flame retardant applied.</p> <p>4. Maintenance Director or Housekeeping Supervisor will make rounds once a week for 12 weeks to ensure stuffed animals, wreaths and artificial floral arrangements have been documented as having flame retardant applied. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.</p>	4/13/13
K 143 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction,</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association, 8.6.2.5.2</p>	K 143		

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From:

04/01/2013 16:06

#221 P.052/055

From:

03/26/2013 13:41

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">186384</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">02/27/2013</p>
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NAME OF PROVIDER OR SUPPLIER FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 MAIN STREET FORDSVILLE, KY 42343
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K 143 Continued From page 25

K 143

1. Maintenance Director will provide a space for the transfilling of oxygen that is outside of the facility in an area specifically designed, designated and appropriate signage displayed by 04/12/2013.
2. Maintenance Director will make observations on oxygen transfilling space to ensure that it is of NFPA Life Safety Code regulation by 04/12/2013.
3. Maintenance Director educated by Administrator on 03/21/2013 using referenced NFPA Life Safety Code regulation.
4. Maintenance Director will make observations once a month for three months to ensure the space for transfilling of oxygen is designed, designated and that the appropriate signage is displayed. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting

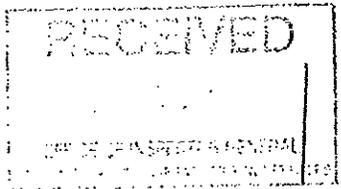
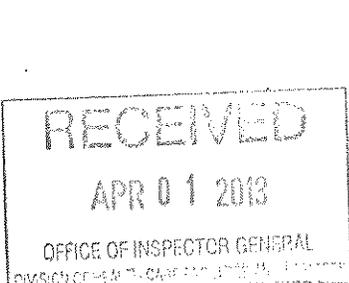
This STANDARD is not met as evidenced by:
Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for Sixty-Seven (67) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure the oxygen transferring room had a one hour fire rated door and the room was mechanically ventilated.

The findings include:

Observation, on 02/27/13 at 3:30 PM, with the Maintenance Director revealed the room designated for transfilling of oxygen was not mechanically ventilated to the outside of the facility. Further observation revealed the door on the room did not have a fire rating of one hour.

Interview, on 02/27/13 at 3:30 PM, with the Maintenance Director revealed he was unaware the room was supposed to be mechanically ventilated to the outside and have a rated door.

Reference: NFPA 99 (1999 Edition).



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: 185354	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2013
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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 143 Continued From page 26
 8-6.2.5.2 Transferring Liquid Oxygen.
 Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:
 a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and
 b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and
 c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.
 Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and procedures of CGA Pamphlet P-2.6, Transferring of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.
 The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling, and Use of Portable Liquid Oxygen Systems in Health Care Facilities.
NFPA 101 LIFE SAFETY CODE STANDARD

K 143

will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.

K 147
 SS=F
 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2

K 147

Maintenance Director will ensure medical equipment is plugged into receptacles and not into power strips in the therapy area; remove the power strip plugged into a power strip in therapy office; power strip plugged into a multi plug in the medical records office; two extension cords plugged into power strip in the Director of

4/13/13

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined this facility failed to ensure electrical

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K 147 Continued From page 27
wiring was maintained 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-Six (66) beds with a census of Sixty (60) on the day of the survey. The facility failed to ensure power strips were being used properly and extension cords were not being used.

The findings include:

Observations, on 02/27/13 between 1:04 PM and 4:00 PM, with the Maintenance Director revealed

- 1) Several medical items were plugged into a power strip located in the therapy area.
- 2) A power strip was plugged into a power strip located in therapy office.
- 3) A power strip was plugged into a multi-plug adapter located in the medical records office.
- 4) Two extension cords were plugged into a power strip located in the Director of Nursing's Office.
- 5) An extension cord was plugged into a power strip that led to another extension cord located in room # 3.
- 6) An extension cord was plugged into the television located in room #18.

Interview, on 02/27/13 between 1:04 PM and 4:00 PM, with the Maintenance Director revealed he was unaware of the power strips and extension cords in use.

Reference: NFPA 70 (1999) ed. 1, 3-3.2.1.2 D

K 147

Nursing's office, extension cord plugged into a power strip, extension cord plugged into a power strip that led to another extension cord in room 3, and extension cord plugged into the television in room 18 by 04/12/2013.

2. Maintenance Director will make observations in the facility to address any further issues with power strips and extension cords by 04/12/2013.

3. Maintenance Director was educated by Administrator on 03/21/2013/2013 using referenced Life Safety Code Regulation. All staff educated by Administrator by 04/12/2013 by using referenced Life Safety Code Regulation.

Maintenance Director will perform observations once a month for three months to ensure all medical equipment is properly plugged into receptacles and power strips when used are being used appropriately. The results of the continued observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, Director

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From:

04/01/2013 16:07

#221 P.055/055

From:

03/26/2013 13:42

#211 P.057/081

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
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K 147 Continued From page 28
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

of Nursing, and Housekeeping Supervisor monthly for three (3) months. The Medical Director will attend at least quarterly. If at any time, issues are identified, a Quality Assurance Committee meeting will be called by the Administrator or Director of Nursing to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.

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