

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

PRINTED: 12/16/2011  
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  12/01/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS  An annual survey and an abbreviated survey (KY #17454) was conducted on 11/28/11 through 12/01/11, and a Life Safety Code survey was conducted on 11/29/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F". KY #17454 was unsubstantiated with no deficiencies.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/26/11
---	------------------------	-----------------------

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

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

PRINTED: 12/16/2011  
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  12/01/2011
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 157	<p>Continued From page 1 this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy/procedure, it was determined the facility failed to notify and report/consult with the physician related to a recommendation and need for a physician's order for a House Supplement, for one resident (#14), in the selected sample of fifteen (15). The Dietician recommended 120 milliliters (ml) of House Supplement two times a day (BID) with medication pass for Resident #14; however, there was no evidence the physician was notified.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure "Notification of Change in Condition," revised July 2011, revealed "notify the physician and family or legal representative at the earliest possible time, during waking hours, if there is a non-critical change in condition."</p> <p>A record review revealed Resident #14 was admitted to the facility on 05/06/11 with diagnosis to Include Failure to Thrive.</p> <p>A review of the "Weights Detail Report" revealed his/her weight, on 09/29/11 was 116 pounds (lbs), on 10/21/11 was 114 lbs, and on 10/25/11, his/her weight was 104.2 lbs.</p>	F 157			

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

PRINTED: 12/16/2011  
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  12/01/2011
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 157	Continued From page 2  A review of the Dietician's Progress Note, dated 10/27/11, revealed the resident was identified with a significant weight loss over a two week period. Further review of the Nutrition Recommendation sheet, dated 10/27/11, revealed the Dietician recommended the resident be started on 120 cubic centimeters (cc) of House Supplement BID, as well as extra butter with meals, and whole milk with breakfast.  An interview with the Dietician, on 11/29/11 at 4:45 PM, revealed she recommended the House Supplement due to the resident's significant weight loss and the decline of a wound.  A review of the physician's orders and the Medication Administration Record (MAR), dated 10/11, revealed there was no evidence the House Supplement 120 cc BID with medication pass was ordered.  Interviews with the Assistant Director of Nursing (ADON) and Licensed Practical Nurse (LPN #2), on 11/30/11 at 2:30 PM, revealed the Dietary recommendations are addressed in the morning meeting and are given to the floor nurse to document interventions on the care plan. They revealed if the recommendations required a physician's order, then the nurse should call and obtain an order, followed by documentation of the physician's order on the MAR. The ADON and LPN #2 stated the nurse placed all the recommendations on the care plan; however, the physician was not notified regarding an order for the House Supplement, so it was not documented on the MAR.	F 157	F 157  1. The Assistant Director of Nursing reviewed resident #14 dietary recommendations with the physician on 12/1/11 with no changes. 2. On 12/19/11 the Assistant Director of Nursing and the Director of Nursing reviewed 30 days of previous dietary recommendations to ensure completion of physician notification with no other issues noted. 3. All Licensed staff will be reeducated by the Director of Nursing on policy and procedure of Physician Notification and documentation of physician acceptance or declination of dietary recommendations by 12/30/2011. 4. The Director of Nursing or Assistant Director of Nursing will review all dietary recommendations weekly x 12 weeks to ensure physician notification is completed. Audits will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.	1/13/12	
F 253	483.15(h)(2) HOUSEKEEPING &	F 253			

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

PRINTED: 12/16/2011  
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  12/01/2011
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 253 SS=B	Continued From page 3 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 review of the facility's Census and Condition, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Observations, on 11/28/11 and 11/29/11, revealed the floor in the main shower room had fluid around the base of the commode. Additionally, there was a strong urine odor in the shower room and an opened lollipop on the shower room floor.  A review of the facility's Census and Condition, dated 11/28/11, revealed there were 61 residents in the facility. Interview with the Maintenance Supervisor, on 11/30/11 at 9:25 AM, revealed approximately 30 residents used the main shower room.  The findings include:  An interview with the Housekeeping Supervisor, on 11/30/11 at 1:10 PM, revealed there was no evidence of a facility policy/procedure to address how often the shower room should be cleaned.  Observations of the main shower room, on 11/28/11 at 1:10 PM and on 11/29/11 at 8:40 AM,	F 253	F 253  1. The identified main shower room was deep cleaned by Housekeeping Services on 12/1/11. There were no odors present, the shower room was clean and there was no fluids around the toilet as noted by the Administrator on 12/1/11. 2. The Administrator and Housekeeping Supervisor made environmental rounds on 12/1/11 to assure the environment was clean and odor free. Any identified concerns were immediately corrected. 3. All Housekeeping staff will be reeducated by the Housekeeping Supervisor on policy and procedure for cleaning the main shower room twice daily by 12/30/11. 4. The Administrator will perform environmental rounds weekly x 12 weeks to ensure a sanitary and orderly environment is maintained. Observations will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.	1/13/12

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

PRINTED: 12/16/2011  
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  12/01/2011
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 253	Continued From page 4 revealed the floor was dirty with fluid around the base of the commode. There was the smell of a strong urine odor in the shower room and an opened lollipop was on the floor in the corner of the shower room. Further observation with the Housekeeping Supervisor, on 11/30/11 at 9:20 AM, revealed the opened lollipop remained in the corner of the shower room.  An interview with the Housekeeping Supervisor, on 11/30/11 at 9:20 AM, revealed the shower room was supposed to be cleaned and mopped two times a day. He stated if the shower room was cleaned properly twice a day, there should not be fluid around the base of the commode, nor a urine odor or a lollipop on the floor.	F 253			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the "Lippincott Manual of Nursing Practice," it was determined the facility failed to ensure one resident (#1), in the selected sample of fifteen (15), received appropriate treatment and	F 315			

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

PRINTED: 12/16/2011  
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  12/01/2011
--	--	--	--

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 315	<p>Continued From page 5</p> <p>services to prevent urinary tract infections (UTI) and to restore as much normal bladder function as possible. An observation, on 11/29/11, revealed a Certified Nurse Aide (CNA) provided Incontinent care for Resident #1 and failed to change the area of the wash cloth after each wipe.</p> <p>The findings include:</p> <p>A review of the "Lippincott Manual of Nursing Practice" revealed "perineal care involved cleansing the perineum, the anus, the vulva (in women) and the penis (in men). Standard precautions should be taken when providing perineal care because contact with body fluids is likely. Always wash toward the anus, away from the urethra. This helps to prevent the spread of microbes from the anus and perineum into the urethra or vagina, where they could cause infections."</p> <p>An interview with the Director of Nursing (DON), on 11/30/11 at 1:36 PM, revealed the facility used the "Lippincott Manual" as a guide and a procedural manual for incontinent care. She revealed the facility followed the standard of practice for incontinent care.</p> <p>A record review revealed Resident #1 was admitted to the facility on 06/18/08 with diagnoses to include Congestive Heart Failure, Chronic Edema, Coronary Artery Disease, Altered Mental Status and Peripheral Vascular Disease.</p> <p>Observation of incontinent care for Resident #1, on 11/29/11 at 4:21 PM, revealed CNA #3 wiped back and forth with the same area of the wash</p>	F 315	<p>F 315</p> <ol style="list-style-type: none"> <li>On 12/19/11 The Director of Nursing observed Resident #1 receiving peri care and noted proper standard of practice and facility policy for peri care was being followed.</li> <li>The Director of Nursing observed peri care and foley catheter care on 12/19/11 to ensure standard practice and facility policy for peri care were followed with no issues noted.</li> <li>All direct care staff will be reeducated by the Director of Nursing on the policy for peri care by 12-30-2011.</li> <li>The Director of Nursing and/or the Assistant Director of Nursing will observe provision of incontinence care 5 x a week x 12 weeks to ensure adherence to policy and procedure for peri care are followed. Observations will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.</li> </ol>	1/13/12
-------	--	-------	---	---------

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

PRINTED: 12/16/2011  
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  12/01/2011
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 315	Continued From page 6 cloth in the resident's right groin area. CNA #3 retrieved a second wash cloth and saturated it with perineal wash, wiped back and forth with the same area of the wash cloth in the left groin area, then wiped down the middle of the resident's perineal area without changing areas of the wash cloth.  An interview with CNA #3, 11/30/11 at 1:15 PM, revealed she provided incontinent care for the resident on 11/29/11. She stated when cleaning the resident, she was supposed to wipe the resident with a different area of the wash cloth each time. She confirmed upon completion of the incontinent care, that she had wiped back and forth with the same area of the wash cloth. She stated she knew to change each area of the wash cloth each time she wiped the resident; however, she stated she "just got nervous."  An interview with the DON, on 11/30/11 at 1:36 PM, revealed when CNAs provided incontinent care, they were expected to gather the equipment, wash their hands, explain the procedure to the resident, provide privacy and then complete the incontinent care. She stated when the CNAs provided the incontinent care, they should wipe from front to back with a different area of the wash cloth each time. During orientation, incontinent care was reviewed and the CNAs completed a return demonstration. Following orientation, incontinent care was reviewed once a year. If issues were identified with incontinent care, then the CNA received additional training and would be monitored by the nurses on the floor for a period of time.	F 315			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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

PRINTED: 12/16/2011  
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  12/01/2011
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 371	Continued From page 7  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, review of the facility's policy/procedure, and review of the Census and Condition, it was determined the facility failed to prepare food under sanitary conditions related to using sanitary cloths to clean the thermometer between each food temperature obtained on the tray line.  A review of the Census and Condition, dated 11/28/11, revealed 56 out of 61 residents consumed food which came from the steam table in the kitchen.  The findings include:  A review of the facility's "Sanitary Procedure for Food Temperatures," last revised July 2004, revealed "the thermometer should be cleaned with an alcohol swab before and after each use."  A review of the "Super Sanitary Cloths" label revealed "hands should be washed thoroughly with soap and water after handling and before eating, drinking, chewing gum, smoking or using	F 371	F 371  1. The super sani wipes were immediately removed from the kitchen by the Dietary Service Manager on 11/28/11 and the Dietary Service Manager observed on 11/29/11 that kitchen staff were using an alcohol prep pad to clean the thermometers. 2. Observations made by the Administrator on 11/28/11 noted the kitchen staff using alcohol prep pads to disinfect thermometers. 3. All Dietary employees will be reeducated by the Dietary Manager on disinfecting thermometers using alcohol by 12/30/11. 4. The Administrator will observe cleaning of thermometers prior to obtaining food temperatures 5 x a week x 12 to ensure compliance with Sanitary Procedure for Food Temperatures. Observations will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.	1/13/12	

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

PRINTED: 12/16/2011  
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  12/01/2011
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 371	Continued From page 8 restroom. Further review of the label revealed "to disinfect non-food contact surfaces only and call poison control center for treatment advice."  An observation of the tray line, on 11/28/11 at 11:00-AM, revealed the Dietary staff used a container of "Super Sanitary Cloths" to clean the thermometer, prior to and after obtaining temperatures of nine food items on the steam table.  An interview with the Dietary Manager, on 11/28/11 at 11:10 AM, revealed she did not read the container prior to the use of the sanitary cloths to clean the thermometers.  An interview with the Dietician, on 11/29/11 at 4:45 PM, revealed she was not aware the dietary staff used the sanitary cloths for cleaning the thermometer prior to obtaining food temperatures. She stated the Dietary Manager did make her aware that they used them for awhile; however, she read the label and determined the sanitary cloths were inappropriate for cleaning the thermometer prior to obtaining food temperatures. She stated the sanitary cloths were removed from the kitchen and they would be using alcohol swabs.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441		

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

PRINTED: 12/16/2011  
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  12/01/2011
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 9</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of</p>	F 441	<p>F 441</p> <ol style="list-style-type: none"> <li>On 12/19/11 The Director of Nursing observed Resident #1 receiving peri care and noted proper standard practice for peri care, handwashing and changing of gloves was being followed as well as the facility policy for pericare was followed.</li> <li>The Director of Nursing observed peri care on 12/19/11 to ensure proper standard practice including handwashing and changing of gloves was followed with no issues noted.</li> <li>All direct care staff will be reeducated by the Director of Nursing on standard precautions including handwashing and changing of gloves by 12/30/2011.</li> <li>The Director of Nursing and/or the Assistant Director of Nursing will observe provision of incontinence care 5 x a week x 12 weeks to ensure adherence to peri care procedure as well as handwashing and changing of gloves are followed. Observations will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the</li> </ol>	1/13/12	

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

PRINTED: 12/16/2011  
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  12/01/2011
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 10</p> <p>disease and infection for one resident (#6), in the selected sample of fifteen (15). An observation of incontinent care for Resident #6, on 11/29/11, revealed the Certified Nurse Aide (CNA) failed to change gloves before applying protective ointment.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Two-Tier Transmission Based Precautions: Standard Precautions," revised November 2011, revealed, "Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms."</p> <p>A record review revealed Resident #6 was admitted to the facility on 02/15/78 with diagnoses to include Mental Retardation, Aphasia, Epilepsy and Abnormal Posture.</p> <p>An observation of provision of incontinent care, on 11/29/11 at 9:35 AM, revealed CNA #1 was observed to provide incontinent care using wash cloths. CNA #2 assisted CNA #1 by squeezing protective ointment onto the glove of CNA #1. CNA #1 then applied the ointment to the resident's sacral and gluteal regions using the same gloves that were used to provide incontinent care.</p> <p>An Interview with CNA #1, on 11/29/11 at 9:50 AM, revealed she should have changed gloves after providing incontinent care, and before applying ointment.</p>	F 441	<p>Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.</p>	1/13/12	

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

PRINTED: 12/16/2011  
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  12/01/2011
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	Continued From page 11  An interview with CNA #2, on 11/29/11 at 10:25 AM, revealed she know to change gloves after provision of incontinent care, and before applying ointment on a resident.  An interview with Licensed Practical Nurse (LPN) #1, on 11/28/11 at 4:15 PM, revealed she expected the staff to change gloves after providing incontinent care, and to apply ointment with clean gloves.  An interview with the Director of Nursing (DON), on 11/28/11 at 4:02 PM, revealed she expected the staff to change gloves after provision of incontinent care, and before applying ointment on a resident.	F 441			

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

PRINTED: 12/16/2011  
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  11/29/2011
NAME OF PROVIDER OR SUPPLIER  FORDSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 313 MAIN STREET FORDSVILLE, KY 42343		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: Unknown  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected  SMOKE COMPARTMENTS: Six (6) smoke compartments.  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLED, SUPERVISED (Dry SYSTEM)  EMERGENCY POWER: Type II LP Generator.  A life safety code survey was initiated and concluded on 11/29/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for sixty-seven (67) beds and the census was sixty-one (61) the day of the survey.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.		

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

TITLE

Administrator

(X6) DATE

12/26/11

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

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

PRINTED: 12/16/2011  
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  11/29/2011
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 062 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to ensure sprinkler system were inspected and maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) smoke compartments, all residents, staff and residents. The facility is licensed for sixty-seven (67) beds and the census the day of survey was sixty-one (61).</p> <p>The findings include: Observation on 11/29/11 between 10:00 AM and 1:30 PM, revealed the sprinkler piping in the Foxes Drive Hell and Harmony Way Hall attic, was being used to support various wiring. Sprinkler piping cannot be used to support building wiring. The observations were confirmed with the Maintenance Director.</p> <p>Interview on 11/29/11 at 1:30 PM, with the Maintenance Director, revealed he was unaware sprinkler piping was being used to support the various wires.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>2-2.2* Pipe and Fittings. Sprinkler pipe and</p>	K 062	<p><b>K 062</b></p> <ol style="list-style-type: none"> <li>The identified sprinkler heads will be replaced by Tri State Fire and Protection by 1/10/12. The Maintenance Director will remove the wires attached to the sprinkler piping by 12/30/11.</li> <li>On 12/19/11 Maintenance Director performed rounds and no other wiring, piping issues identified. On 12/19/11 the Maintenance Director was reeducated by the Administrator on ensuring the sprinkler heads are free of paint and performing inspections of the sprinkler heads from the floor level annually and ensuring the sprinkler piping is not used to support building wiring.</li> <li>The Administrator will perform environmental rounds weekly x 12 weeks to ensure sprinkler heads are free of debris. The Maintenance Director will inspect the sprinkler piping monthly x 3 months and annually thereafter to ensure piping is not used to support building wiring. Audits will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures</li> </ol>	1/13/11

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

PRINTED: 12/16/2011  
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  11/29/2011
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 062	Continued From page 2 fittings shall be inspected annually from the floor level. Pipe and fittings shall be in good condition and free of mechanical damage, leakage, corrosion, and misalignment. Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe.  Exception No. 1:* Pipe and fittings installed in concealed spaces such as above suspended ceilings shall not require inspection.  Exception No. 2: Pipe installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.  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 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction	K 062	dependent upon the root cause to assure ongoing compliance.	

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

PRINTED: 12/16/2011  
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  11/29/2011
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 062	Continued From page 3 valve and by removing two cross main flushing connections Based on observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practices affected three (3) of six (6) smoke compartments. The facility is licensed for sixty-seven (67) beds and the census the day of the survey was sixty-one (61).  The findings include:  During the Life Safety Code survey on 11/29/11, between 10:00 AM and 1:30 PM with the Maintenance Director, paint was noted on the seven (7) sprinkler heads in the corridor of Foxes Drive Hall, one(1) in Foxes Drive Hall soiled utility room and one(1) by the smoke doors in Harmony Way Hall. Not maintaining sprinkler heads can decrease their ability to react as intended.  Interview with the Maintenance Director on 11/29/11, at 1:15 PM, revealed he was not aware the paint was a deficiency.  Reference: NFPA 25 (1998 Edition).  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices are prohibited in	K 070		

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

PRINTED: 12/16/2011  
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  11/29/2011
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 070	<p>Continued From page 4</p> <p>all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters used in the facility were approved, according to National Fire Protection Association (NFPA) standards.</p> <p>The findings include:</p> <p>Observation on 11/29/11 at 1:00 PM, revealed portable space heater in the Business Office. The heater was energized and ready for use. Portable space heaters are prohibited in health care facilities.</p> <p>Interview on 11/29/11 at 1:00 PM, with the Maintenance Director, revealed he was unaware of the portable space heater.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 070	<p>K 070</p> <ol style="list-style-type: none"> <li>1. The portable space heater was immediately removed from the Business Office by the Maintenance Director on 11/29/11.</li> <li>2. The Maintenance Director performed an inspection of facility and no other space heaters observed in use.</li> <li>3. Management staff will be reeducated by the Maintenance Director by 12/30/11 on the prohibited use of portable space heaters.</li> <li>4. The Maintenance Director will perform facility rounds weekly x 12 weeks to ensure portable space heaters are not in use. Audits will be reviewed by the Quality Assurance committee monthly x 3 months. If at any time concerns are identified the Quality Assurance committee consisting of the Administrator, Director of Nursing, Social Service Director, the Facility Rehabilitation Coordinator, and the medical director at a minimum quarterly, will convene to analyze and implement further measures dependent upon the root cause to assure ongoing compliance.</li> </ol>	1/13/11