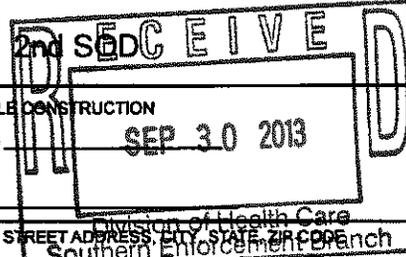


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/17/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185451	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  08/08/2013
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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1016 ROBERT L TELFORD DRIVE RICHMOND, KY 40475
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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	F 000		
F 274 SS=D	<p>A standard health survey was conducted on 08/06-08/13. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and a review of the Minimum Data Set (MDS) reference manual, the facility failed to ensure a comprehensive assessment had been completed within fourteen days after a significant change in status that would not normally resolve on its own for one of ten sampled residents (Resident #2). The facility failed to conduct a significant change in resident status assessment when Resident #2 became enrolled in a hospice (end of life care) program.</p> <p>The findings include:</p>	F 274	<p>83.20 (b) (2) (ii) COMPREHENSIVE ASSESSMENT AFTER A SIGNIFICANT CHANGE</p> <p>1) No resident was identified to have had an adverse outcome from this deficient practice. A significant change assessment has been completed for the resident #2 identified to have been affected by this deficit practice.</p> <p>2) All residents have been audited to ensure a significant change assessment (comprehensive) has been completed per MDS Guidelines for any noted significant change in status that would not normally resolve itself without further intervention by staff.</p> <p>3) The MDS Coordinator/personal staff has been in-serviced by the Director of Nursing on 08/30/2013 regarding the criteria in completing a significant change assessment within 14 day of with any noted significant change in status that would not normally resolve itself without further intervention by staff.</p> <p>The Resident Assessment policy has been revised to indicate when to conduct a significant change assessment (comprehensive) as well as indicating the time frame to complete it in.</p> <p>4) The MDS Coordinator will track all residents for a significant change assessment on an ongoing basis to ensure continued compliance. A significant change log has been established to monitor all residents having the potential for a significant change per MDS Guidelines. The Director of Nursing will review the significant change log in the Standards of Care meeting weekly to ensure continued compliance.</p> <p>5) Completion Date 09/05/2013</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert J. Lewis</i>	TITLE Administrator	(X6) DATE 9/30/2013
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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 disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
(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 274	Continued From page 1  A review of the "Long Term Care Resident Assessment Instrument User's Manual (MDS 3.0)," dated April 2012, revealed a significant change in status assessment must be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the facility. The manual also revealed the assessment reference date must be no later than 14 days from the date the resident was enrolled in the hospice program.  A review of the facility's policy titled, "Resident Assessment Instruments," which contained no date, revealed the policy did not identify a timeframe the MDS Coordinator would be required to perform a significant change in status assessment for the residents.  A review of the medical record for Resident #2 revealed the facility admitted the resident on 08/07/12 with diagnoses including Chronic Kidney Disease, Sub-endocardial Myocardial Infarction, Dementia, Congestive Heart Failure, and Diabetes Mellitus. A review of the Hospice Referral Agreement and Plan of Treatment for Resident #2 revealed the resident was admitted to hospice services on 06/21/13. A review of the MDS assessments for Resident #2 on 08/07/13 revealed a quarterly MDS assessment had been completed by the MDS Coordinator for Resident #2 on 06/27/13. However, there was no evidence a significant change assessment was completed for Resident #2 after the resident was enrolled in the hospice program.  An interview conducted with the MDS Coordinator on 08/08/13, at 4:30 PM, revealed she was responsible for completing MDS assessments for	F 274		

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F 274	Continued From page 2 the residents. The MDS Coordinator stated she had not been aware a significant change in status assessment was required for all residents when they were admitted to hospice programs.  An interview conducted with the Director of Nursing (DON) on 08/08/13, at 4:45 PM, revealed she also was not aware a significant change in status assessment was required when a resident was admitted to a hospice program. The DON stated she monitored MDS assessments for timeliness, and also reviewed the MDS assessments prior to any care plan conferences. The DON stated she had not identified any concerns with the MDS assessments conducted by the MDS Coordinator.	F 274			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to provide an environment that was free from accident hazards and adequate supervision to prevent accidents. Observation of the common shower room on 08/06/13 at 3:00 PM revealed resident toiletries, brushes/combs, and hair dryers and curling irons on a covered linen cart in	F 323	F 323.25 (h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES 1) No resident was identified to have had an adverse outcome from this deficient practice. All items indicated in the resident areas have been removed from the shower room & soiled linen cart. All hazardous items have been placed under locked storage. 2) All residents have the potential to be affected therefore, an audit of all residents areas have been conducted to ensure no other areas were affected by this deficient practice. 3) A salon caddy with a lockable door has been purchased for the shower room for the storage of the appliances. An in-serviced was conducted by the Quality Assurance Nurse on 08/15/2013 for all staff regarding environmental hazards & safety, the appropriate storage of personal items, hair care appliances and storage of chemicals. A Shower Aide Job Description has been established.		

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F 323	<p>Continued From page 3</p> <p>the shower room and within resident reach. Further observation revealed an unplugged curling iron on a locked cabinet next to the sink in the shower room, also within resident reach.</p> <p>The findings include:</p> <p>Review of the facility's Universal Precautions policy (no date) revealed that universal precautions will be followed during the care of all residents.</p> <p>Observations conducted of the residents' common shower room on 08/06/13 at 3:00 PM revealed a covered, three-shelf linen cart. Shelf 1 contained two 33.8-oz. pump bottles of Head &amp; Shoulders shampoo; two cans of Barbasol shave cream; two bottles of prescription shampoo for an individual resident; a handheld hair dryer; one container of Aloe Vesta foaming bath/cleanser; a physician prescribed container of Cetaphil skin cleanser for Resident #8; three pump bottles of facility peri-wash; a container of nail polish remover that was labeled as highly flammable; a container of lavender scented body lotion/mist; nylon corded beads; two cans of Rave hair spray; Brut hairspray; White Rain hair spray; Herbal Essence hairspray; a container of Suave aerosol deodorant; three cans of Degree spray deodorant; a container of baby powder; a shower cap; and a hair brush.</p> <p>Shelf 2 contained ¾ box sterile wooden ear swabs; a sleeve of cotton pads; a small wicker basket that contained unused cosmetic applicator sponges; two pairs of bandage scissors; two pairs nail clippers; ¼ box of wooden manicure sticks with pointed ends; a bottle of Hyrocerin moisturizing cream; a roll of clear small plastic</p>	F 323	<p>4) To ensure continued compliance a Quality Assurance Audit will be conducted by the Quality Assurance Nurse on a monthly basis to assure residents environment is free of accident hazards.</p> <p>5) Completion Date 09/05/2013</p>		

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
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F 323	<p>Continued From page 4</p> <p>bags; two bottles of Coloplast Isagel antiseptic hand gel (call poison control); a rat tail comb and hair pick; an oxygen tank key; a container with four brushes, nine combs, and two hair picks; and a basket with twelve bottles of body mist, perfumes, and aftershave lotion.</p> <p>Shelf 3 contained a bottle of Germ Away foaming germicidal cleaner (call poison control); Tilex mold/mildew remover with bleach (call poison control); five scrub brushes; a brush; three curling irons; a hair dryer; and a gallon pump bottle each of hair/body wash and body lotion.</p> <p>During the observation, an ambulatory resident entered the shower room to use the bathroom. Record review of the facility's Wandering Residents/Elopement Risk revealed there were nine residents that were at risk to enter the shower room with the toiletries and hair care appliances.</p> <p>Continued observations on 08/07/13 at 9:15 AM revealed shaving cream, hairspray, deodorant, and a brush and hair pick on the top of the cabinet in the common shower room.</p> <p>Further observation on 08/08/13 at 9:00 AM revealed a tub of Sani Wipes (a disinfecting wipe) sitting on top of the locked cabinet in the common shower room.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 08/07/13 at 9:15 AM revealed there was a usual bath aide but she was on vacation and the other staff was giving the showers while she was gone. She further stated that to her knowledge, there was not a description of the duties for a bath aide or anyone assigned</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186451	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2013
NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475		
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F 323	<p>Continued From page 5 to give showers.</p> <p>Interview with SRNA #2 on 08/07/13 at 9:25 AM revealed that she brought the resident's own toiletries/brushes when she gave a shower and returned the items to the resident's room when finished. Further interview revealed it was a safety issue to leave appliances plugged in or lying where residents could reach them.</p> <p>Interview with SRNA #3 on 08/07/13 at 9:35 AM revealed she had been the aide assigned to give showers on 08/06/13. She further stated that the usual bath aide routinely left shower supplies out on the weekends for staff use and that the locked cabinet only had one key and the bath aide would have it with her. Continued interview revealed she only used the resident's personal toiletries, that it was a safety issue to leave appliances plugged in or within resident reach and that there had not been any education on what should or should not be left out in the shower room.</p> <p>Interview with SRNA #4 on 08/07/13 at 9:40 AM revealed she usually used the resident's toiletries but would sometimes use the unlabeled toiletries on the linen cart for residents.</p> <p>Interview with SRNA #5 on 08/07/13 at 9:45 AM revealed she would use the resident's brush/comb, but would use the toiletries on the linen cart and put the hair care appliances on the linen cart.</p> <p>Interview with SRNA #6 on 08/07/13 at 9:55 AM revealed she only used the resident's personal items when she gave showers.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 323			

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F 323	Continued From page 6 08/06/13 at approximately 3:15 PM revealed she was not aware that the linen cart in the common shower room contained anything but linens. She further stated it was a safety issue for the toiletries, hair care appliances, and brushes and combs to be left out within resident reach. Continued interview revealed the usual bath aide was on vacation and had inadvertently taken the only key to the locked cabinet with her. Continued interview with the DON on 08/08/13 revealed the shower aide should not have taken the key with her to the cabinet or left the Sani Wipes sitting out within reach of residents that might enter the shower room unsupervised. Further interview revealed the facility did not have a shower aide job description.	F 323			
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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	F 441	<b>F 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 1) No resident was identified to have had an adverse outcome from this deficient practice. All items indicated in the resident areas have been removed from the shower room & soiled linen cart. All appliances have been disposed of and replaced with new appliances. 2) All residents have the potential to be affected therefore, an audit of all residents areas have been conducted to ensure no other areas were affected by this deficient practice. 3) A salon caddy with a lockable door has been purchased for the storage of the appliances for the shower room to ensure safety in the resident areas. An in-serviced was conducted by the Quality Assurance Nurse on 08/15/2013 for all staff regarding infection control measures in preventing the spread of infection from resident to resident, the appropriate storage/care of personal items, and the appropriate storage and sanitation of hair care appliances in order to prevent the spread of infections.		

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F 441	<p>Continued From page 7</p> <p>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 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 observations and interviews, it was determined the facility failed to have an effective infection control program. Observations during the environmental tour and staff interviews revealed staff was using hair care appliances, brushes/combs, and hair picks for more than one resident without cleaning and sanitizing them.</p> <p>The findings include: Review of the facility's Universal Precautions policy (no date) revealed that universal precautions will be followed during the care of all residents.</p> <p>Observations during the environmental tour on 08/08/13 revealed a covered three-shelf linen cart with numerous brushes, combs, hair picks, and curling irons with hair and scalp residue on them.</p>	F 441	<p>4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis by the Quality Assurance Nurse regarding infection control (preventing the spread of infection from resident to resident).</p> <p>5) Completion Date 09/05/2013</p>		

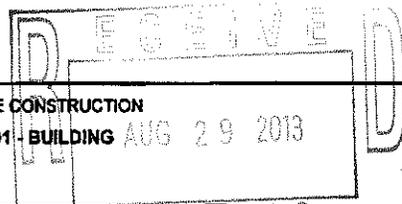
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F 441	Continued From page 8  Interview with State Registered Nurse Aide (SRNA) #1 on 08/07/13 at 9:20 AM revealed she was unaware of a process to clean/sanitize the brushes/combs and hair care appliances between resident use.  Interview with SRNA #4 on 08/07/13 at 9:40 AM revealed that she sometimes used plain water to clean the brushes/combs between resident uses.  Interview with the Infection Control Nurse on 08/08/13 at 5:40 PM revealed her expectation was for staff to use universal precautions in regard to use of the shower room toiletries and hair care appliances for residents.	F 441			

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475
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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 2000  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (000)  SMOKE COMPARTMENTS: 3  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)  EMERGENCY POWER: Type II natural gas generator  A life safety code survey was initiated and concluded on 08/07/13. 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.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Robert A. Shaw* TITLE: Administrator DATE: 8/28/2013

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
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K 025	<p>Continued From page 1</p> <p>least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected one of three smoke compartments, staff, and all the residents. The facility has the capacity for 56 beds with a census of 43 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 08/07/13, at 11:30 AM, with the Assistant Director of Maintenance (ADOM), unsealed penetrations around piping and electrical conduit were observed in the fire/smoke barrier wall located in the attic area. A section of sheetrock was also observed to have pulled away from the framing. In a fire situation, defective fire/smoke barrier walls aid in the spread of smoke and fire to other parts of the building.</p> <p>An interview with the ADOM on 08/07/13, at 11:30 AM, revealed he was unaware the fire/smoke barrier wall was damaged. The ADOM stated he</p>	K 025	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>1) No resident was found to have been affected by this deficient practice.</p> <p>2) A full inspection of the attic area found no additional areas of concern.</p> <p>3) All areas around conduit and loose wires will be sealed with an approved fire-rated caulk. The drywall will be secured to the wall.</p> <p>4) To ensure continued compliance a quarterly audit will be conducted of accessible attic areas.</p> <p>5) completion Date: 09/06/2013</p>	

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IDENTIFICATION NUMBER OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185451	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  08/07/2013
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NAME OF PROVIDER OR SUPPLIER  FORD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475
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K 025	<p>Continued From page 2</p> <p>was aware the fire/smoke barrier wall should be maintained.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol> <p>19.1.1.3 Total Concept.</p> <p>All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because</p>	K 025		
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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 025	Continued From page 3 the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 025			
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an exit door was accessible in accordance with NFPA standards. This deficient practice affected one of three smoke compartments, residents, staff, and visitors. The facility has the capacity for 56 beds with a census of 43 on the day of the survey.  The findings include:	K 038	NFPA 101 LIFE SAFETY CODE STANDARD  1) No resident was found to have been affected by this deficient practice.  2) An inspection of the magnetic locks on the rear service doors revealed a small gap between the magnetic lock and the connector plate that caused the misalignment. No sign was present indicating that this door has magnetic locks and that the door could be released by holding the door lock in the open position for 15 seconds.  3) A small adjustment was make and the door has been operating properly. cont'd		

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	<p>Continued From page 4</p> <p>During the Life Safety Code tour on 08/07/13, at 10:40 AM, with the Assistant Director of Maintenance (ADOM), a double exit door leading from the back entrance of the facility was observed to have time delayed magnetic locks. There was no signage on the door on how to release the magnetic door lock in order to leave the facility in an emergency situation as required. The magnetic lock on one of the doors would not release during testing.</p> <p>An interview with the ADOM on 08/07/13, at 10:40 AM, revealed he was not aware that there should be proper signage on these doors. The ADOM was unsure if the facility tested magnetic locks on exit doors for proper operation.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p>	K 038	<p>3) cont'd</p> <p>A temporary sign with the words PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS has been installed and a permanent sign with letters at least 1" tall and 1/8" in stroke has been ordered.</p> <p>4) To ensure continued compliance all magnetic lock doors will be tested monthly and a log will be maintained.</p> <p>5) Completion Date: 08/28/2013</p>	08/28/2013

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475
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K 038

Continued From page 5  
 (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  
 (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.  
 (d) \* On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:  
 PUSH UNTIL ALARM SOUNDS  
 DOOR CAN BE OPENED IN 15 SECONDS  
 Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

K 038

K 052  
 SS=F

NFPA 101 LIFE SAFETY CODE STANDARD  
 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

K 052

NFPA 101 LIFE SAFETY CODE STANDARD  
 1) No resident was identified to have been affected by this deficient practice.  
 2) The smoke barrier doors and the magnetic locks were inspected and tested on several occasions since the LSC inspection. Our staff was unable to recreate the problem stated in the deficiency.

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1026 ROBERT L TELFORD DRIVE RICHMOND, KY 40475		
(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 052	Continued From page 6  This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure the fire alarm system was being maintained according to NFPA standards. This deficient practice affected three of three smoke compartments, staff, and all the residents. The facility has the capacity for 56 beds with a census of 43 on the day of the survey.  The findings include:  During the Life Safety Code tour on 08/07/13 at 11:10 AM with the Assistant Director of Maintenance (ADOM), a test of the facility fire alarm system revealed the two sets of fire/smoke barrier cross-corridor doors would close when the alarm was activated but could be reset while in the silent mode to the open position while the system was still showing fire conditions. These doors should not reengage until the fire alarm system is reset and showing normal conditions.  An interview with the ADOM on 08/07/13 at 11:10 AM revealed he was not aware the fire/smoke barrier doors should not be able to be reset while the fire alarm system is still showing fire conditions.  The findings were revealed to the Administrator upon exit.  Reference: NFPA 72 (1999 Edition).  3-9.6.3 All door hold-open release and integral door	K 052	3) A licensed fire alarm technician was called to inspect the doors, alarm, and magnets to ensure proper operation. American Fire & Security did a full alarm operation, the doors closed properly, the alarm was silenced, and the doors were returned to the open position. The magnets did not engage. AF&S a licensed fire alarm inspection company has verified the correct operation of the smoke corridor doors.  4) To ensure continue compliance the smoke barrier cross-corridor doors will be tested with every fire drill and recorded on the fire drill log.  5) Completion Date:	08/27/2013	

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NAME OF PROVIDER OR SUPPLIER  TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
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K 052	Continued From page 7 release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052		
K 062 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 record review, the facility failed to maintain the sprinkler system according to NFPA standards. This deficient practice affected three of three smoke compartments, staff, and all the residents. The facility has the capacity for 56 beds with a census of 34 on the day of the survey.  The findings include:  During the Life Safety Code tour on 08/07/13, at 10:30 AM, with the Assistant Director of Maintenance (ADOM), observation of the facility's sprinkler system riser revealed a valve in the off position to the accelerator. An accelerator ensures the proper operation of the sprinkler system.  An interview with the DOM on 08/07/13 at 10:30 AM revealed he was not aware if the accelerator needed to be repaired or replaced. A quarterly inspection dated 07/16/13 did not reveal if the accelerator needed to be repaired or replaced.	K 062	NFPA 101 LIFE SAFETY CODE STANDARD  1) No resident was found to be affected by this deficient practice.  2) An inspection of the sprinkler system riser revealed a valve for the accelerator in the off position. The sprinkler system had been inspected on July 16, 2013 and was in good operating condition.  3) The sprinkler system riser valve for the accelerator was turned to the on position by a certified technician from American Fire & Security.  4) To ensure compliance the sprinkler system riser valve for the accelerator will be part of the inspection for sprinkler system gauges and the air compressor.  5) Date completed:	08/27/2013

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K 062	Continued From page 8 The findings were revealed to the Administrator upon exit.	K 062		