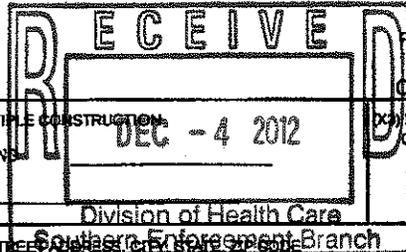


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 11/08/2012
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 10/25/2012
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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE	STREET ADDRESS (OR STATE OFFICE) 1025 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
F 000	INITIAL COMMENTS	F 000		
F 253 SS=B	<p>A standard health survey was conducted on 10/23-25/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Resident room doors were scarred with indentations in the wood from door handles scraping the door. A decorative support column on the aviary/bird habitat was observed to have a large hole at the bottom of the column near the floor.</p> <p>The findings include:</p> <p>A review of the facility policy titled Maintenance Services, revised 01/04/12, revealed it was facility policy for staff to fill out maintenance slips and place in the Maintenance box located at the nurses' station when problems were identified with the resident environment.</p> <p>Observations conducted during an environmental tour conducted on 10/24/12 at 10:00 AM, revealed doors were visibly scratched with indentations in the wood from door handles.</p>	F 253	<p>483.15 (h) (2) Housekeeping and Maintenance Services</p> <p>1) No resident was identified to have had an adverse outcome from this deficit practice.</p> <p>2) All residents have the potential to be affected therefore, an audit of all residents room doors have been conducted to ensure no other resident's doors was affected by this deficit practice.</p> <p>3) All the resident's doors that were affected are being patched in order to remove the indentations and scratched areas, the hole in the aviary/bird habitat column was repaired with a vinyl patch.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert A. Skew TITLE: CAO (X6) DATE: 12/04/2012

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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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 10/25/2012
NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40476		
(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 1 rubbing the door in resident rooms 101, 102, 104, 105, 106, 108, and 114. A decorative support column on the aviary/bird habitat was observed to have a large hole, approximately six inches by six inches, at the bottom of the column near the floor. An interview conducted with the Maintenance Director on 10/25/12 at 2:10 PM, revealed the Maintenance Director was aware of the damage to the doors. The Maintenance Director stated he had not repaired the doors because he "thought the doors had to be replaced and could not be repaired." Further interview revealed the Maintenance Director was aware of the hole in the aviary/bird habitat but the damage to the column had not been repaired because the Maintenance Director was not sure how to repair the hole. An interview conducted with RN #1 on 10/25/12 at 3:00 PM, revealed RN #1 had conducted monthly QA audits for concerns with facility appearance and had identified the damage to the resident room doors. The RN had not identified the hole in the aviary/bird habitat during the QA audits. According to the RN, no QA action had been taken related to the doors not being repaired.	F 253	The Quality Assurance Nurse has been in-serviced regarding when audits are conducted and areas have been identified for plan of corrections that they are to followed-up to see that it has been completed. 4) To ensure continued compliance a Quality Assurance Audit will be conducted on a monthly basis. 5) Completion Date	12/21/2012	
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.	F 323			

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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 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as was possible. Doors to mechanical rooms were not locked and the threshold to resident room 206 was loose with a sharp nail protruding from the floor at the bottom of the doorway.</p> <p>The findings include:</p> <p>An interview conducted with the Maintenance Director on 10/25/12 at 2:10 PM, revealed the facility did not have a written policy regarding the mechanical room doors. However, it was facility practice to secure the doors.</p> <p>Observations on 10/24/12 at 10:00 AM, revealed the mechanical room door in the facility dining room was unlocked allowing access to a heating and air unit with access to electrical connections, a mechanical room door in the hallway by the dining room was unlocked allowing access to construction materials and tools, and a mechanical closet that housed two hot water heaters in the hallway near the nurses' station was not locked. Additional observations on 10/25/12 at 2:10 PM, revealed a threshold in resident room 208 was observed loose with a sharp nail protruding from the floor at the bottom of the doorway.</p> <p>An interview conducted with the Maintenance</p>	F 323	<p>483.25(h) Free of accident Hazards/supervision/devices</p> <p>1) No resident was identified to have been affected by the mechanical room door not being locked. The resident's room in 206 was noted to have a sharp nail protruding from the floor of the doorway, however, there was no adverse outcome from this deficit practice.</p> <p>2) All resident's have the potential to be affected, therefore an audit was conducted on all resident's room to ensure no other sharp objects were identified from the floor of the doorways. All other mechanical rooms were audited to ensure locked and secured.</p> <p>3) The carpet bar was installed with a drive pin</p>		

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1026 ROBERT L TELFORD DRIVE RICHMOND, KY 40476		
(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 323	Continued From page 3 Director on 10/25/12 at 2:10 PM, revealed the Maintenance Director did not routinely check to ensure the mechanical room doors were locked and was not aware the mechanical room that housed the hot water heaters was required to be locked. According to the Maintenance Director, he was not aware of any residents entering the mechanical rooms. Additional interview revealed the floor in room 206 had been recently replaced. The Maintenance Director stated he had been having problems with the thresholds but was not aware of the loose threshold or the nail protruding from the threshold in room 206. An interview conducted with RN #1 on 10/25/12 at 3:00 PM, revealed that Quality Assurance (QA) room audits are completed monthly to identify concerns in resident rooms. According to RN #1, checking to ensure mechanical room doors were secure was not part of any current QA audits.	F 323	and the loose nail was removed and repaired immediately. The Maintenance Director and staff have been in-serviced regarding the importance of keeping the mechanical room doors locked. A check list has been devised to see that rounds are conducted to ensure that the mechanical room doors are locked. A Quality assurance audit has been devised to ensure compliance. 4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis. 5) Completion Date		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		12/04/2012	

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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 329	<p>Continued From page 4</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure the residents' drug regimen was free from unnecessary drugs for six of ten sampled residents. A review of the medical records for Residents #1, #3, #5, #7, #8, and #9 revealed they contained medication orders in doses and duration that were not based on the resident's clinical condition or were without adequate indications for use. Each of the resident's medical records included "Standing Physician Orders for Symptom Management" which were not individualized for the resident's assessed condition.</p> <p>The findings include:</p> <p>A review of the facility's Standing Physician Orders policy (no date given) revealed when a resident was admitted to the facility a copy of the Standing Orders for Symptom Management was to be sent to their physician for approval. Upon approval by the physician, the signed copy was to be placed in the resident's permanent chart.</p>	F 329	<p>483.23 (1) Drug Regimen is free from unnecessary drugs.</p> <p>1) The resident's #1, #3, #5, #7, #8 and #9 that was identified to be affected by this deficit practice had no adverse outcome.</p> <p>2) Although resident's #1, #3, #5, #7, #8 and #9 had standing orders no resident had an adverse outcome due to the fact that no resident had received any medications per the "Standing Physicians Orders".</p> <p>3) The Director of Nursing, in agreement with the Medical Director, conducted an in-service discontinuing the use of "Standing</p>		

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F 329	Continued From page 5 1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 08/15/12 with diagnoses that included Hypertension, Acute Renal Failure, Hypoxic Respiratory Failure, Peripheral Artery Disease, History of Transient Ischemic Attacks, and Dysphagia. Additional review of the medical record revealed standing physician orders for Resident #1 dated 08/15/12, with orders for the resident to have Temazepam 15 milligrams (mg) by mouth every night at bedtime for insomnia as needed, Lorazepam 0.5 mg every four hours as needed for anxiety/agitation, and Diphenhydramine 25 mg every four hours as needed for pruritus. Additional review of the medical record revealed no evidence of an indication for the use of these medications. There was no evidence Resident #1 had a diagnosis of insomnia, agitation/anxiety, or pruritus. 2. A review of the medical record for Resident #3 revealed the facility admitted the resident on 05/22/11 with diagnoses that included Coronary Artery Disease, Cerebrovascular Accident, Chronic Renal Failure, and Anxiety. Further review of the medical record revealed Resident #3 was ordered to have Diazepam 5 mg daily at bedtime for anxiety and Paxil 40 mg daily for anxiety. Additional record review revealed Resident #3 had standing physician's orders for Temazepam 15 mg by mouth every night at bedtime as needed for insomnia, Lorazepam 0.5 mg every four hours for anxiety/agitation as needed, and Diphenhydramine 25 mg every four hours as needed for pruritus. There was no evidence of an indication for the use of these medications or evidence Resident #3 had a	F 329	Physician Orders". 4) A monthly chart review audit will be conducted by the Medical Records Department to ensure no further "Standing Physician Orders" are being used in this facility. The audit will be conducted monthly x 3 months to ensure continued compliance. 5) Completion Date 12/04/2012		

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F 329	<p>Continued From page 6</p> <p>diagnosis of insomnia or pruritus. Resident #3 did have a diagnosis of anxiety which was being treated with Diazepam and Paxil with no rationale for the use of duplicate therapy for the treatment of anxiety with the Lorazepam.</p> <p>3. A review of the medical record for Resident #5 revealed the facility admitted the resident on 3/14/11 with diagnoses that included Dementia with Psychosis, Depression, Gastroesophageal Reflux Disease, Hypothyroidism, Asthma, Arthritis, and Behavioral Disturbance. A review of the "Standing Orders" included orders for insomnia: Temazepam 15 mg at bedtime as needed for insomnia; and for diarrhea: Lomotil 2.5 mg as needed for diarrhea, may repeat every four hours, not to exceed 15 mg in 24 hours. In addition, for impaired skin integrity there was an order to treat a Stage II pressure sore with Silvadene: apply to affected area as needed; clean with sterile H2O/soap, cover with Telfa twice daily and as needed.</p> <p>There was no indication in Resident #5's medical record that he/she had a diagnosis of insomnia or diarrhea or had developed pressure sores.</p> <p>4. A review of the medical record for Resident #7 revealed the facility admitted the resident on 9/13/04 with diagnoses that included Diabetes, Hypertension, Bipolar Disorder, Manic with Psychotic Features, Alzheimer's Dementia with Behaviors, Hypercholesterolemia, Depression, Cerebrovascular Accident, Urinary Retention, and Allergies. A review of physician's orders for Resident #7 revealed "Standing Orders" for dyspnea: Albuterol Inhaler - inhale 1 puff, repeat every six hours as needed for shortness of</p>	F 329		

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F 329	<p>Continued From page 7</p> <p>breath/wheezing; for nausea/vomiting: Promethazine 25 mg every six hours as needed for nausea/vomiting, may use per rectum if needed; for diarrhea: Lomotil 2.5 mg for diarrhea as needed, may repeat every four hours, not to exceed 15 mg in 24 hours; and for dyspnea: Guaifenesin DM 10 milligrams/milliliter (mg/ml), give 5 ml every four hours as needed for cough and Guaifenesin 100 mg/5 ml, give 10 ml every four hours as needed for cough/congestion.</p> <p>There was no indication in Resident #7's medical record that he/she had a diagnosis related to dyspnea, diarrhea, or nausea and vomiting.</p> <p>5. A review of the medical record for Resident #8 revealed the facility admitted the resident on 05/17/12 with diagnoses that included Psychosis, Special Agitation, Dementia, Alzheimer's Disease, and Insomnia. Additional review revealed the resident was ordered to have Temazepam 15 mg daily at bedtime, Trazodone 100 mg daily at bedtime, and Geodon 20 mg twice daily in the morning and at bedtime. A review of standing physician's orders for Resident #8 revealed the resident was ordered an additional Temazepam 15 mg mouth every night at bedtime for insomnia as needed, Lorazepam 0.5 mg every four hours for anxiety/agitation as needed, and Diphenhydramine 25 mg every four hours as needed for pruritus. Resident #8 did not have a diagnosis of anxiety and there was no documented rationale for the use of the Lorazepam. In addition there was no evidence Resident #8 had a diagnosis of pruritus. Resident #8 did have a diagnosis of insomnia which was being treated with Temazepam 15 mg daily with no evidence of the rationale for the</p>	F 329			

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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 329	<p>Continued From page 8 additional Temazepam every night as needed.</p> <p>6. A review of the medical record for Resident #9 revealed the facility admitted the resident on 03/10/11 with diagnoses that included Deafness, Chronic Anemia, History of Neck Fracture, Acute and Chronic Heart Failure, History of Ovary Surgery, Bilateral Hearing Loss, Hyponatremia, and Osteoarthritis. A review of the physician's orders for Resident #9 revealed "Standing Orders" for pruritus: Diphenhydramine 25 mg by mouth every four hours as necessary for pruritus; Lorazepam 0.5 mg by mouth every four hours as needed for agitation/anxiety, and Miralax 17 grams/capful by mouth every day as necessary for constipation.</p> <p>There was no indication in Resident #9's medical record the resident had a diagnosis related to pruritus, anxiety/agitation, or constipation.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 10/25/12 at 4:20 PM, revealed some residents' physicians used the Standing Orders when the resident was admitted to the facility. LPN #1 stated she would notify the resident's physician before using the resident's standing orders because she did not feel comfortable using some of the medications that were listed on the orders without notifying the physician. Further interview revealed the nurse would use "nursing judgment" if a resident was already on the medication and also had standing orders for the same medication.</p> <p>An interview conducted with LPN #2 on 10/25/12 at 4:43 PM, revealed the LPN could use the standing orders without notifying the physician</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40476		
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F 329	<p>Continued From page 9</p> <p>because the physician had reviewed and approved for use the standing orders for the resident. Additional interview revealed if a resident was already on a medication that was listed on the standing orders, the nurse was to use a different medication listed on the standing orders. According to LPN #2, the nurse wrote the order from the standing order sheet for the medication per the standing orders, retrieved from the emergency box, and administered to the resident. According to LPN #2, the standing orders could be used without notifying the physician. However, LPN #2 stated the physician was always notified when the resident had a change of condition.</p> <p>An interview with the Director of Nursing (DON) conducted on 10/25/12 at 5:08 PM, revealed when a resident was admitted the physician could agree or disagree with standing orders approved by the Medical Director. If a resident has a change of condition and requires intervention staff has to write a telephone order to use a standing order. Additional interview with the DON revealed the telephone orders were reviewed daily to identify concerns with the standing order use or excessive use of medication and none had been identified. According to the DON, the standing orders were used to prevent the resident from having to wait for treatment.</p> <p>An interview conducted with the facility pharmacist on 10/25/12 at 6:08 PM, revealed the pharmacist was aware of the use of standing orders and had not identified any concerns regarding the use of the standing orders.</p> <p>An interview with the physician who utilizes</p>	F 329			

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F 329	Continued From page 10 standing orders for his residents on 10/25/12 at 6:50 PM, revealed when a resident is admitted, the physician reviews the standing orders and approves medications to be used for the resident. According to the physician, if a resident was already on a medication listed on the standing orders, the nurse should not use the same medication. According to the physician, he was always notified when a nurse used a medication on the standing orders and was not aware of any concerns related to the standing orders. Further interview revealed the rationale for the standing orders was so that a resident would not have to wait for an order before being treated.	F 329		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain essential mechanical equipment in a safe operating condition. An eyewash faucet was missing from the laundry handwashing sink that was designated as an eyewash station for laundry personnel. The findings include: An interview conducted with the Laundry Supervisor on 10/25/12 at 3:40 PM, revealed the facility did not have a policy regarding the maintenance of the eyewash station in the	F 456	483.70 (c) (2) Essential Equipment, Safe Operating Condition 1)No resident was identified to have been affected by this deficit practice. 2)An audit of the facilities eyewash stations was conducted to ensure no other areas were affected by this deficit practice.	

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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: 186461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/25/2012
NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40476		
(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 456	<p>Continued From page 11 laundry area.</p> <p>Observation of the facility Laundry conducted on 10/24/12 at 1:44 PM, revealed a sign indicating an eyewash station was located at the hand sink. Further observation revealed the sink was not equipped with an eyewash faucet.</p> <p>An interview conducted with the Laundry Aide on 10/24/12 at 1:51 PM, revealed the eyewash faucet had been removed by Maintenance approximately three months ago because the faucet was in need of repair.</p> <p>An interview conducted with the Laundry Supervisor on 10/25/12 at 3:40 PM, revealed Maintenance had removed the eyewash faucet for repair; however, the Supervisor could not remember the date, stating at least a "couple of months" ago. According to the Laundry Supervisor, no work order had been filled out.</p> <p>An interview conducted with the Maintenance Director on 10/25/12 at 2:10 PM, revealed the Maintenance Director was not aware the eyewash faucet had been removed from the laundry room sink by Maintenance staff nor had he received a work order for repair.</p>	F 456	<p>3)The eyewash faucet was replaced and repaired. The staff has been in-service regarding when the equipment is in need of repair that a maintenance slip is to be filled out and forwarded to the maintenance department for repairs.</p> <p>4)To ensure continued compliance a Quality Assurance Audit will be conducted on a monthly basis.</p> <p>5)Completion Date</p>	12/04/12	

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40476
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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: 2 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 10/23/12. 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 L. Skun* TITLE: CAD DATE: 12/04/2012

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 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 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 fire/smoke barrier doors. This deficient practice affected two of two smoke compartments, staff, and all the residents. The facility has the capacity for 50 beds with a census of 45 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 10/23/12 at 12:05 PM, with the Director of Maintenance (DOM), an access door in the fire/smoke barrier wall in the attic area was observed to be ajar and did not have a self-closing device as required. Fire/smoke barrier doors must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. Fire/smoke barriers must be reasonably accessible for inspection and maintenance purposes. A door in the foyer was a part of this fire/smoke barrier. It was observed to be held open by a magnetic hold-open device, and was not connected to the fire alarm system.</p>	K 025	<p>1) No resident was found to have been affected due to this deficient practice.</p> <p>2) An inspection of the building identified no other areas that could be effected.</p> <p>3)The access door in the attic will have a new self-closing hinge installed. A door providing reasonable access (for inspection) to the attic will be installed. The magnetic door hold-open device has been removed.</p> <p>4)The facility plans to monitor these areas by having a quarterly inspection of the fire/smoke barrier/ doors/walls in the attic area to meet standards. A sign will be posted on the fire/smoke corridor door noting that it must be kept closed to meet safety standards.</p> <p>5)Completion Date 12/28/2012</p>	

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K 025	Continued From page 2 Doors in smoke barriers are required to remain closed or can be held open if the closing device is connected to the fire alarm system. An interview with the DOM on 10/23/12 at 12:05 PM, revealed he thought he had put a closing device on the fire/smoke barrier door in the attic. The DOM stated this part of the attic was not reasonably accessible for inspection and maintenance purposes and he would add access to this area. The DOM stated he was unaware the door in the foyer could not be held open in this manner. Reference: NFPA 101 (2000 Edition). 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 19.3.7.8* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 025			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029			

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K 029	<p>Continued From page 3</p> <p>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 permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors to hazardous areas were maintained as required. This deficient practice affected one of two smoke compartments, residents, staff, and visitors. The facility has the capacity for 50 beds with a census of 45 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 10/23/12 at 10:50 AM, with the Director of Maintenance (DOM), corridor doors to the laundry and kitchen were observed to have gaps and/or door closure problems. These doors must be properly maintained to help prevent smoke and fire from spreading to exit access corridors and other health care areas.</p> <p>An interview with the DOM on 10/23/12 at 10:50 AM, revealed he was aware these doors should be maintained. The DOM stated he was unaware</p>	K 029	<p>1) No resident was found to have been affected by this deficient practice.</p> <p>2) An inspection of the building found no other doors to be affected by this deficient practice.</p> <p>3) The door from the laundry room to the corridor was determined to be warped and has been replaced. The doors between the kitchen and the dining area have been ordered.</p> <p>4) To ensure continued compliance a Quality Assurance will be conducted on a monthly basis.</p> <p>5) Completion Date 12/28/2012</p>		

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1026 ROBERT L TELFORD DRIVE RICHMOND, KY 40476		
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K 029 K 046 SS=D	Continued From page 4 the doors needed repair. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting at an exit according to NFPA standards. This deficient practice affected one of two smoke compartments, residents, staff, and visitors. The facility has the capacity for 50 beds with a census of 45 on the day of the survey. The findings include: During the Life Safety Code tour on 10/23/12 at 12:25 PM, with the Director of Maintenance (DOM) an exterior exit located from the new wing was observed to have an approximate 30-yard long sidewalk that led to a parking lot. There was no source of emergency lighting to this area in case of a power outage as required. An interview with the DOM on 10/23/12 at 12:25 PM, revealed he was not aware the exit needed emergency lighting along the sidewalk to the parking lot. Reference: NFPA 101 (2000 Edition). 7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42	K 029 K 046	1) No resident was found to have been affected due to this deficient practice. 2) An inspection of the buildings emergency lighting found no other areas affected by this deficient practice. 3) A flood light connected to the back-up power supply will be installed to provide the necessary emergency lighting. 4) This area shall be maintained as an exit with emergency lighting until an addition may be added to the existing structure. 5) Completion Date	12/07/2012	

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K 046	Continued From page 5 For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 046			
K 062 SS=D	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 and interview, the facility failed to ensure that sprinkler requirements were maintained. This deficient practice affected one of two smoke compartments, residents, staff, and visitors. The facility has the capacity for 50 beds with a census of 45 on the day of the survey. The findings include: During the Life Safety Code survey on 10/23/12 at 11:55 AM, with the Director of Maintenance (DOM), storage in the attic area of the garage was observed to be blocking sprinkler coverage. An interview with the DDM on 10/23/12 at 11:55 AM, revealed the storage was not supposed to be in the attic area. Reference: NFPA 13 (1999 Edition).	K 062	1) No resident was found to have been affected due to this deficient practice. 2) An inspection of the building identified no other attic areas were used for storage that could be affected by this deficient practice. 3) The items stored in the attic will be removed. An in-service was conducted with the Maintenance department and staff regarding no further storage items to be stored in the attic area except for items limited to repair and maintenance of HVAC units and if those items are stored they are not to block the sprinkler systems. 4) To ensure compliance a new policy will be established that restricts the storage of items in the attic unless that area has been built for that purpose. A sign will be posted noting access only not for storage. 5) Completion date	12/28/2012	

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K 062	Continued From page 6 5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.	K 062			