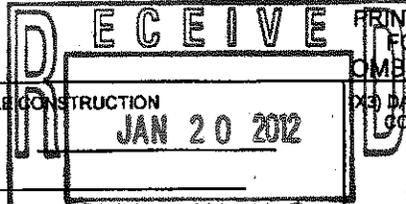


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 01/11/2012
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 2/22/2011
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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE	STREET ADDRESS Division of Health Care Southern District Office - Men Branch 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 166 SS=E	<p>A standard health survey was conducted on 12/20-22/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure efforts to resolve resident grievances were made promptly. A review of Resident Council meeting minutes for October, November, and December 2011 revealed the residents expressed concerns to the facility related to cold/undercooked food, a desire to have cottage cheese and fresh fruits more often, and call lights not always answered timely. However, there was no evidence that the facility attempted to resolve these grievances or that the facility informed the residents of any actions taken.</p> <p>The findings include:</p> <p>A review of the facility's Grievance Policy (no date given) revealed grievances and/or complaints could be submitted orally or in writing. According to the policy, the resident or the person filing the written grievance and/or complaint on behalf of the resident would be informed of the findings of the investigation and the actions that would be</p>	F 166	<p>483.10 (f) (2) Right to prompt efforts to resolve grievances</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 the Resident Council Policy and Procedure has been revised to ensure residents concerns have been addressed and follow-up has been conducted with the residents.</p> <p>3) Facility Department Directors have been in-serviced regarding the facility's revised Resident Council Policy and Procedure. A resident council follow-up form has been devised in order to ensure areas of concern have been addressed and followed through.</p> <p>Different rolls have been purchased and will be served warm. Fresh fruits/vegetables are to be offered on the selective menu weekly and on an individual basis per resident preference. Grilled cheese and meal substitutes are to be prepared upon request as close to meal service as possible.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Albert L. Shaw</i>	TITLE CAO	(X6) DATE 01/20/2012
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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 166	<p>Continued From page 1.</p> <p>and/or were taken to correct any identified problems.</p> <p>An interview was conducted with Resident #3 on 12/20/11, at 12:45 PM, and revealed the breads the facility served to residents were always cold when served. Resident #3 further stated that the Resident Council had expressed the complaint to the facility but there had been no improvement.</p> <p>A group interview was conducted with four alert/oriented residents on 12/21/11, at 3:00 PM. The residents complained the combread and rolls served at the facility were cold when served, the cakes were dry, and they wanted more fresh fruit served. In addition, the residents stated the call bells were not answered timely. Residents confirmed they had made the facility aware of the cold bread.</p> <p>A review of the Resident Council minutes dated 10/23/11 confirmed residents had expressed to the facility that some of the soups served were not warm enough, that grilled cheese and meal substitutes were prepared too early and were served hard and cold. In addition, a review of the minutes also revealed the residents had requested fresh fruit occasionally. The document also revealed residents had reported the call bells were not always answered timely.</p> <p>A review of the Resident Council minutes dated 11/07/11 revealed the residents had complained the vegetables served by the facility were undercooked, the gelatin was too watery and there were no "good" snacks for diabetics. In addition, the residents requested cottage cheese and fruit to be served more often. The residents</p>	F 166	<p>Cottage cheese/fruit is to be offered weekly on the selective menu and on an individual basis per resident request with meal or snack of choice.</p> <p>Reviewed the diabetic snack list with residents in the resident council. No further suggestions requested. Residents' will have name/label placed on diabetic snacks per individual preference when snacks are offered. Staff in-serviced regarding the re-checking of soup temps prior to leaving the dietary department. Staff in-serviced on preparation of moist cakes versus dry cakes and moist tender meats versus dry hard meats and under cooked vegetables. Staff in-serviced regarding answering of call-bells in a timely manner.</p> <p>4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.</p>	01/09/12

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F 166	<p>Continued From page 2</p> <p>also complained the call bells were not answered timely.</p> <p>Resident Council minutes dated 12/13/11 revealed the residents' complaints included combread/rolls were always dry and cold, cakes were too dry, and the meat was dry, hard, and difficult to chew. Residents also requested fresh fruit, new snacks for diabetic residents, and fresh vegetables for snacks. In addition, the residents complained the call bells were not answered timely.</p> <p>An interview with the Activity Director (AD) on 12/22/11, at 10:45 AM, revealed the AD attended the Resident Council meetings and gave a copy of the minutes to all Department Heads. According to the AD, the Quality Assurance Coordinator was to follow up with the residents. The AD further stated that she read the minutes of the previous month's meeting to the Council for review and if residents said the situation was better or they had no concerns she assumed it was resolved.</p> <p>An interview with the Dietary Manager (DM) on 12/22/11, at 2:30 PM, revealed the DM was unaware she could address the Resident Council directly and address their concerns. The DM stated she had attempted to address complaints of which she was aware.</p> <p>An interview with the Director of Nursing (DON) and the Quality Assurance (QA) Coordinator on 12/22/11, at 1:40 PM, revealed the complaints/concerns expressed by residents were given to the pertinent discipline and that particular discipline had the responsibility to</p>	F 166			

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F 166	Continued From page 3 ensure the problems were resolved if possible and that the residents were informed of the facility's actions. The DON stated she assumed the residents were informed of any follow-up related to their concerns when the AD read the minutes from the previous month's Council meeting to the residents. A second interview conducted with the DON and QA Coordinator on 12/22/11, at 3:30 PM, revealed the QA Coordinator had conducted audits related to call bells not answered timely and had not identified any problems.	F 166		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, the facility failed to ensure care was delivered according to professional standards of quality for one of eleven sampled residents (Resident #1). Resident #1 had physician's orders related to catheter care and the use and position of a bed cradle. However, observations revealed these orders were not followed. The findings include: A review of the facility policy related to Monthly Physician Orders (no date given) revealed that all physician orders, Medication Administration Records (MARs), and Treatment Administration Records (TARs) were to be checked by licensed	F 281	483.20(k)(3)(i) Services provided meet professional standards 1)The resident that was affected by the deficit practice had no adverse outcome. 2)An audit of all other residents with the use of a Foley Catheter/ bed cradle was conducted to ensure no other resident was affected by the deficit practice. 3)Staff was in-serviced regarding the appropriate placement of Foley. Catheter tubing and drainage bag. Staff was in-serviced regarding how to appropriately place the bed linens when a bed cradle is in use. Staff was also in-serviced regarding how to ensure catheter tubing is secured and if not secured properly to notify the charge nurse. The nurse aide orientation checklist was revised to include the care and placement of Foley Catheter tubing /drainage bag and the appropriate use of a bed cradle	

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F 281	<p>Continued From page 4</p> <p>nurses to ensure resident safety and accuracy. Further review of the Foley Catheter Care Policy (no date given) revealed the urinary bag was to be positioned lower than the bladder at all times to prevent the urine in the tubing/drainage bag from flowing back into the urinary bladder and the bag/drainage bag was to be kept off and out of direct contact with the floor. In addition, the policy directed staff that the catheter was to be secured to reduce friction/movement at the insertion site and that unsecured catheters were to be reported to the supervisor.</p> <p>A review of the physician's orders for Resident #1 revealed staff was to provide catheter care for the resident. On 04/28/11, physician's orders revealed the resident's suprapubic catheter drainage bag was to be kept off the floor. On 05/26/11, based on documentation, the resident's physician requested the resident's suprapubic catheter be taped to the resident's abdomen in an effort to secure the catheter. Further review of physician's orders revealed the physician had written an order on 03/04/11, for a bed cradle to be placed at the foot of the resident's bed in an effort to prevent contact of the linens with the resident's foot.</p> <p>Observations on 12/20/11, at 2:35 PM, revealed the resident was in bed and although a bed cradle was on the bed the cradle was not in use. The bed cradle was placed over the bed linens which covered and were in contact with the resident's foot. Further observation revealed the catheter drainage bag was lying on the floor.</p> <p>Observations on 12/21/11, at 10:15 AM, revealed the bed cradle remained on the bed on top of the</p>	F 281	<p>4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.</p>	01/04/2012

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F 281	Continued From page 5 bed linens which were covering the resident's feet. Further observations during care delivery by staff revealed the catheter was not taped to the resident's abdomen as ordered by the physician. Staff completed care, repositioned the resident in bed, and exited the room. The catheter tubing was observed to be over the top of the side rail and the drainage bag was on the floor. An interview with the Certified Nursing Assistant (CNA) on 12/20/11, at 10:00 AM, revealed the resident's catheter was not taped to the abdomen as requested by the physician, and she had not reported this information to the supervisor. The CNA further stated she was aware that drainage bags were not to be placed on the floor. An interview with the Registered Nurse (RN) on 12/22/11, at 2:50 PM, revealed she was aware the resident's catheter was to be taped to the abdomen and no staff had reported to her that the catheter had not been secured. The RN further stated she did not know why the bed cradle had not been used properly or why the urinary drainage bag was lying on the floor. An interview with the Director of Nursing (DON) on 12/22/11, at 11:00 AM, revealed nurses were to monitor resident care to ensure physician's orders were followed.	F 281			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS		

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F 431	<p>Continued From page 6</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure expired biologicals were not available for resident use. Observations revealed numerous expired biological items stored in a common area and available for resident use.</p>	F 431	<p>1) No resident was identified to have been affected by this deficit practice.</p> <p>2) An audit of other facility biologicals was conducted to ensure no other areas were affected by the same deficit practice.</p> <p>3) The outdated biologicals have been disposed. The designated staff members assigned to rotating the biologicals have been in-serviced related to the checking of expiration dates on all biological items stocked within the facility. A biologicals log has been devised assigning weekly monitoring of biologicals with expiration dates. A policy and procedure has been devised on Storage of Medical Biologicals.</p> <p>4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.</p>	1/4/2012

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F 431	<p>Continued From page 7</p> <p>The findings include:</p> <p>An interview on 12/21/11, at 3:58 PM, with the Director of Nursing revealed the facility did not have a policy for the storage of medical supplies and biologicals or to ensure biological supplies were not stored past the manufacturer's expiration dates.</p> <p>An observation on 12/21/11, at 10:00 AM, of the medication/supply storage room revealed numerous biological supplies that had exceeded the manufacturer's recommended expiration dates.</p> <p>Based on observation:</p> <ol style="list-style-type: none"> Seven bottles of Sween Isagel hand gel had a manufacturer's expiration date of May 2011 and remained available for resident use seven months after the expiration date. Three boxes of CarraGauze had expiration dates of August 2008 and remained available for resident use three years and four months after the expiration date. One box that contained 100 3-ml syringes had an expiration date of September 2010 and remained available for resident use one year and three months after the expiration date. One box that contained 25 60-ml syringes had an expiration date of September, 2011 and remained available for resident use three months after the expiration date. Two pairs of Triflex Sterile Latex Gloves had 	F 431		

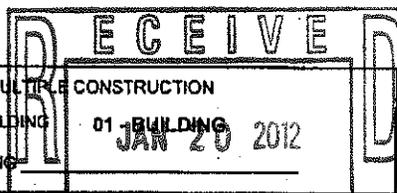
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F 431	<p>Continued From page 8</p> <p>an expiration date of December 2010 and remained available for resident use one year after the expiration date.</p> <p>6. Three packages of Medical Action Industries Sharp Debridement Trays had an expiration date of June 2008 and remained available for resident use three years and five months after the expiration date.</p> <p>7. Eight Promagram Matrix wound dressings had an expiration date of October 2009 and remained available for resident use two years and two months after the expiration date.</p> <p>8. Two hydrogen peroxide bottles had an expiration date of April 2008 and remained available for resident use three years and eight months after the expiration date.</p> <p>An interview on 12/21/11, at 10:23 AM, with the Admission Coordinator revealed she had the responsibility to order supplies and take inventory and she was not aware of the expiration dates for the above supplies. She also stated that a new employee recently began to assist with the placement of the supplies on the shelves and had not always rotated the supplies, had not placed the older supplies in front of the newer supplies, and had not always monitored the expiration dates of the items. She also stated she had not always monitored the expiration dates of the stock to ensure outdated products were not available for use.</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE	STREET ADDRESS CITY STATE ZIP CODE 105 ROBERT TELFORD DRIVE RICHMOND, KY 40475
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2000</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Two.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 12/21/11. 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE: *Robert A. Hew* TITLE: *CAO* (X6) DATE: *01/20/2012*

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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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K 038	Continued From page 1 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 maintain exits according to NFPA standards. This deficient practice affected one of two smoke compartments, staff, and no residents. The facility has the capacity for 50 beds with a census of 42 on the day of the survey. The findings include: During the Life Safety Code tour on 12/21/11, at 11:15 AM, with the Director of Maintenance (DOM) an exterior exit located in the new wing of the facility was observed not to have a durable surface to the public way. An interview with the DOM on 12/21/11, at 11:15 AM, revealed the exit was left without a durable surface to the public way because the facility plans on building on another addition in the future. Reference: NFPA 101 (2000 Edition). 7.7.1: Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all	K 038	K 038 NFPA 101 LIFE SAFETY CODE STANDARDS Exit access is arranged so that exits are readily accessible at all times. 1) No resident was identified to have been affected by this deficit practice. 2) All residents have the potential to be affected, therefore an exit access is to be implemented. 3) A hard surface sidewalk has been installed from the existing exit apron to the closest public way. 4) This area shall be maintained as an exit access until an addition may be added to the existing structure.	01/06/12

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STATEMENT 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 12/21/2011
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 2 occupants with a safe access to a public way. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038		
K 072 SS=F	CMS Ref: S&C-05-38 NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridors and corridor doors according to NFPA standards. This deficient practice affected two of two smoke compartments, staff, and approximately twenty-two residents. The facility has the capacity for 50 beds with a census of 42 on the day of the survey. The findings include: During the Life Safety Code tour on 12/21/11, at 11:45 AM, with the Director of Maintenance (DOM) an exit access corridor located near the dining room was observed to have boxes, a shopping cart, a piano, and other storage in the corridor. Corridors are intended for means of	K 072	K 072 NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments: 1) No resident was identified to have been affected by this deficit practice. 2) All residents have the potential to be affected by this deficit practice therefore a policy and procedure for the use of mesh stop signs has been devised and corridors will remain free of any objects that would be an impediment during an emergency, as well as access doors will remain unlocked. 3) Staff in-serviced regarding keeping corridors clear of objects that could impede the instant use during an emergency. Staff in-serviced about all access doors must remain unlocked in case of an emergency, and the proper use of the mesh-stop sign per the policy and procedure. The piano has been removed to another location in the new addition (Activities Room). All boxes and tubs have been stored in a proper location. The shopping cart has been removed. The mesh-type stop signs have all been removed. A mesh stop sign assessment form has been devised. The laundry room lock has been replaced with a standard passageway unit (no lock).	

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K 072	Continued From page 3 egress, internal traffic, and emergency use, not storage spaces. The Life Safety Code has specific requirements for storage spaces. An interview with the DOM on 12/21/11, at 11:45 AM, revealed he has made staff aware of storing items in the corridor but staff does not adhere to his advice. On 12/21/11, at 11:50 AM, a door leading out of the laundry was observed to be locked from the other side of the door. This locked door could put people in danger in a fire situation. An interview with the DOM on 12/21/11, at 11:50 AM, revealed this lock was added about two years ago because of an office area being added on the other side of this door. On 12/21/11, at 12:20 PM, resident room 110 was observed to have a mesh-type stop across the door opening. This type of stop can be used on a limited basis due to a specific resident health need. An interview with the DOM on 12/21/11, at 12:20 PM, revealed this method is used to keep wandering residents out of other resident rooms. During the survey 12 other resident doors were observed to be using this mesh-type stop device across the door openings. Reference: NFPA 101 (2000 Edition). 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.	01/17/12
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable	K 073		

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K 073	<p>Continued From page 4 character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure decorations were noncombustible or flame-retardant as required. This deficient practice affected one of two smoke compartments, staff, and all of the residents. The facility has the capacity for 50 beds with a census of 42 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 12/21/11, at 12:15 PM, with the Director of Maintenance (DOM) rooms 101 and 102 were observed to be covered with an unapproved decorative wrapping. An interview with the DOM on 12/21/11, at 12:15 PM, revealed the DOM was aware that unapproved decorations were not permitted in health care areas. The DOM stated that his advice to staff on this matter is not followed. During the survey 17 other corridor doors were observed to have unapproved decorative wrapping and or decorative wreaths attached to the doors.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or</p>	K 073	<p>K-073 NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 1) No resident was identified to have had an adverse outcome from this deficit practice. 2) All resident have the potential to be affected therefore, a policy has been devised regrading flame retardant decorations. 3) A letter was devised to be issued out to the resident/family member regarding the use of flame retardant decorations. A log has been devised for maintenance staff to log items requiring the application of a flame retardant coating when family members are unable to provide proof of noncombustible decorations. All decorations that are not flame retardant are to receive a flame retardant coating and logged in the tracking book. The Flame Retardant Policy has been added to the Admission Agreement Booklet. 4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.</p>	01/31/12	

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K 073	Continued From page 5 spread is not present. 10.3.5* Furnishings or decorations of an explosive or highly flammable character shall not be used. A.10.3.5 Christmas trees not effectively flame-retardant treated, ordinary crepe paper decorations, and pyroxylin plastic decorations might be classified as highly flammable. 10.3.6 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under service conditions encountered in actual use.	K 073			