

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

2nd SOD

PRINTED: 07/18/2014
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 07/03/2014
NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT D. 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 000	INITIAL COMMENTS A standard health survey was initiated on 06/30/14 and concluded on 07/03/14. Deficient practice was identified with the highest scope and severity at "F" level.	F 000			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	483.20(b)(1) COMPREHENSIVE ASSESSMENTS 1) On 07/03/2014 the Director of Nursing (DON) reviewed resident #2 and #8 medical records and functional status and identified that no adverse outcome was noted from this deficit practice. A comprehensive assessment correction has been completed for the resident #2 and #8 identified to have been affected by this deficit practice. 2) On 07/10/2014 all residents were audited by DON and Minimum Data Set Coordinator(MDS) to ensure a comprehensive assessment has been completed per MDS Guidelines and for any noted bowel and bladder assessment discrepancies. No other residents were found to be affected by this deficit practice. 3) On 07/03/2014 the MDS Assistant was immediately in-serviced by Quality Assurance (QA) Nurse on regarding the criteria in coding bowel and bladder assessment per guidelines. On 07/17/2014 MDS staff and all licensed nursing staff was in-serviced by the DON and QA Nurses on correctly assessing the resident's bowel and bladder status. cont'd.		

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

Robert S. Skew

TITLE

Administrator

(X6) DATE

08/22/2014

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 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 272	Continued From page 1 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to complete an accurate comprehensive assessment for two (2) of ten (10) sampled residents. Resident #2 was admitted to the facility on 12/18/13 and an admission MDS (Minimum Data Set) was done on 12/25/13. Resident #2 was assessed to be frequently incontinent of bladder and always continent of bowel. However, the CAA (Care Area Assessment) summary stated that Resident #2 was incontinent of bowel and bladder and failed to assess the resident's continence and a toileting plan to meet the resident's needs. Resident #2 had a quarterly MDS assessment completed on 06/16/14 that stated that Resident #2 was always incontinent of bowel and always incontinent of bladder. However, a review of the nurse aide assignment sheets revealed that Resident #2 was often continent during the assessment period. Resident #8 was admitted to the facility on 03/20/14 and was assessed on the admission MDS dated 03/27/14 to be frequently incontinent of bowel and bladder. The CAA summary dated 03/27/14 stated that the resident was frequently incontinent of bowel and bladder, but did not address that the resident was continent at times and failed to accurately assess Resident #8's toileting needs (refer to F279, F315, and F323).	F 272	P 272 Cont'd 4) The corrective action will be monitored as follows, the MDS Coordinator will review weekly all comprehensive assessments (per MDS scheduler) completed by the MDS Assistant. Weekly the DCN will compare 10% of resident census intake & output records against current bowel and bladder assessments to ensure accuracy. The Interdisciplinary Team will discuss weekly, during the standard of care meeting, any changes in all resident's bowel and bladder status. As part of the facilities QA program the QA Nurse will conduct random monthly audits on 10% of current resident census to ensure MDS assessment accuracy. 5) Completion Date:	07/17/2014	

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F 272	<p>Continued From page 2</p> <p>The findings include:</p> <p>A review of the facility's "Continence Program" (no date) revealed that the facility was required to assess each resident's elimination status and develop an appropriate care plan and interventions within seven to ten days after admission.</p> <p>1. Resident #2 was observed on 07/01/14 at 9:45 AM and 07/02/14 at 10:15 AM ambulating in the hallway with the assistance of a walker and one staff member. An interview conducted with Resident #2 on 06/30/14 at 3:05 PM revealed the resident was aware when he/she needed to urinate or have a bowel movement and called for staff assistance to the restroom. However, staff did not always assist the resident timely and the resident attempted to go to the restroom without assistance at times.</p> <p>Record review revealed that Resident #2 was admitted to the facility on 12/18/13 with diagnoses that included coronary artery disease, anemia, difficulty walking, muscle weakness, and syncope. A review of Resident #2's comprehensive Minimum Data Set (MDS) assessment dated 12/15/13 revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicates no cognitive impairment. The MDS also stated that Resident #2 was frequently incontinent of urine and always continent of bowel. The Care Area Assessment (CAA) summary for urinary incontinence dated 12/31/13 stated that Resident #2 was incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. The quarterly MDS assessment that</p>	F 272		

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F 272	<p>Continued From page 3</p> <p>was completed on 06/16/14 revealed the facility assessed Resident #2 to be always incontinent of urine and always incontinent of bowel. However, a review of the nurse aide assignment sheets for June 2014 revealed that Resident #2 was continent every day.</p> <p>Further review of the record revealed that the "Assessment for Bowel and Bladder Training" had been completed on 12/18/13 and again on 03/19/14 and 06/17/14. The 12/18/13 and 03/19/14 assessments stated that the resident was unable to participate in a training program due to weakness and requiring assistance. The plan for management was to toilet the resident before and after meals, at bedtime, and as needed. The 06/17/14 assessment stated that the resident was able to participate in a training plan due to occasional incontinence secondary to weakness and that the resident knew when he/she needed to go to the restroom. The plan for management was to toilet the resident before and after meals, at bedtime, and as needed.</p> <p>An interview with the direct care staff, CNA (Certified Nurse Aide) #6, on 07/02/14 at 10:00 AM revealed that Resident #2 was often continent, but had incontinence episodes at times. She also stated that the resident called for assistance when needing to go to the restroom and had always done so since being at the facility.</p> <p>An interview with CNA #7 on 07/01/14 at 1:15 PM revealed that Resident #2 was aware of the need to use the restroom and usually rang her call light for assistance to the restroom. CNA #7 stated staff offered to assist Resident #2 with going to the restroom every two hours.</p>	F 272			

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F 272	<p>Continued From page 4</p> <p>2. Resident #8 was observed on 07/03/14 at 11:15 AM ambulating in the hallway with the assistance of a walker and two staff members. The resident's sister was observed pushing a wheelchair behind the staff members.</p> <p>A review of the record for Resident #8 revealed that the facility admitted the resident on 03/20/14 with diagnoses that include dementia and a fractured femur. The admission MDS dated 03/27/14 revealed that Resident #8 had a BIMS score of 6 which indicates cognitive deficits. Resident #8 was also assessed to be frequently incontinent of urine and frequently incontinent of bowel. A review of the CAA summary dated 03/27/14 revealed that Resident #8 was alert and oriented with confusion. Furthermore, the CAA summary stated that Resident #8 was frequently incontinent of bowel and bladder, and that he/she was toileted before and after meals. The "Assessment for Bowel and Bladder Training" dated 03/20/14 stated that Resident #8 was "unable to recognize the urge to urinate or defecate" due to a diagnosis of Alzheimer's dementia.</p> <p>An interview conducted on 07/03/14 at 12:18 PM with direct care staff, CNA #1, revealed that Resident #8 often asked to go to the restroom and recognized the urge to go. CNA #1 further stated that the resident was both incontinent and continent at times.</p> <p>On 07/02/14 at 3:27 PM, an interview with the Director of Nursing (DON) revealed that the Assistant Director of Nursing (ADON) or the nurse who admits the resident completed the "Assessment for Bowel and Bladder Training."</p>	F 272			

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F 272	Continued From page 5 The DON reviewed the assessments for Resident #2 and Resident #8 and stated that she felt that the staff had incorrectly assessed the residents and that the residents should be able to participate in a training or continence program. An interview with the MDS nurse on 07/03/14 at 10:00 AM revealed that when a resident triggered for incontinence, they were placed on a two-hour toileting plan. She stated that the facility did not assess Resident #2 or Resident #8 for patterns of incontinence or develop an individualized plan for Resident #2 or Resident #8 to address his/her incontinence.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 1) On 07/03/2014 the Director of Nursing (DON) reviewed resident #2, #6, and #8 comprehensive care plans and identified that no adverse outcome was noted from this deficit practice. A comprehensive care plan has been completed to reflect the current resident functional status for the residents #2, #6, and #8 identified to have been affected by this deficit practice. 2) On 07/10/2014 the DON and Minimum Data Set (MDS) Coordinator reviewed all resident's medical records to ensure a comprehensive care plan had been completed and reflects resident's current treatment plan and functional status. No other residents were identified to have been affected by this deficient practice. 3) On 07/03/2014 the MDS Coordinator, MDS Assistant, and all licensed nursing staff was in-serviced by the Quality Assurance (QA) Nurse regarding the importance of up-dating and maintaining each residents individualized comprehensive care plan to reflect current treatment and functional status. On 07/08/2014 the DON, Hospice Supervisor, and Hospice Nurse met to discuss hospice contract and the services required per contract to complete the comprehensive care plan for each Hospice resident. Cont'd.	

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F 279	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a plan of care was developed for three (3) of ten (10) sampled residents. Resident #2 and Resident #8 were assessed by the facility to have incontinence and require incontinence care. However, the facility failed to develop individualized care plans for each of these residents that addressed their toileting needs. In addition, Resident #2 sustained eight falls at the facility from 01/28/14 through 06/16/14. The facility failed to assess each fall and revise Resident #2's plan of care to prevent further falls (refer to F272, F315, and F323). Resident #6 received hospice services and the facility failed to develop a care plan to include the resident's hospice needs.</p> <p>The findings include:</p> <p>1. A review of the facility's "continence program" (no date) revealed the facility was to assess each resident's elimination status and develop an appropriate care plan and interventions within seven to ten days after admission.</p> <p>Resident #2 was observed on 07/01/14 at 9:45 AM and 07/02/14 at 10:15 AM ambulating in the hallway with the assistance of a walker and one staff member. An interview conducted with Resident #2 on 06/30/14 at 3:05 PM revealed that the resident was aware when he/she needed to urinate or have a bowel movement and requested assistance from staff to the restroom; however, at times staff told the resident that he/she had to wait for assistance. Resident #2 stated that</p>	F 279	<p>P 279 Cont'd</p> <p>4)The corrective action will be monitored as follows; the DON and Medical Records personnel will perform weekly ongoing audits of comprehensive care plans on 10% of resident census to ensure accuracy. As part of the facilities QA program the QA Nurse will complete monthly on-going random audits of 10% of current resident census. The QA Nurse will review comprehensive care plans and care plan conferences to ensure they reflect current treatment and current status of the resident.</p> <p>5) Completion:</p>	07/14/2014	

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F 279	<p>Continued From page 7</p> <p>usually when he/she fell it was because he/she got up without assistance to go to the restroom.</p> <p>Record review revealed that Resident #2 was admitted to the facility on 12/18/13 with diagnoses that included coronary artery disease, anemia, difficulty walking, muscle weakness, and syncope.</p> <p>A review of Resident #2's comprehensive Minimum Data Set (MDS) assessment dated 12/15/13 revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicates no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #2 as being frequently incontinent of urine and always continent of bowel. However, a review of the Care Area Assessment (CAA) summary for urinary incontinence dated 12/31/13 revealed the facility assessed Resident #2 as being incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes.</p> <p>A review of the care plan for Resident #2 dated 01/03/14 and updated 04/03/14 revealed the facility assessed the resident to have problems with urinary incontinence. The care plan stated that Resident #2 was occasionally incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. In addition, the care plan stated facility staff would provide perineal care after each incontinence episode and staff would assist the resident with toileting before and after meals. However, a review of the nurse aide assignment sheets for June 2014 revealed that Resident #2 was continent every day.</p>	F 279		

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F 279	<p>Continued From page 8</p> <p>An interview with the direct care staff, CNA (certified nurse aide) #6, on 07/02/14 at 10:00 AM revealed that Resident #2 was often continent, but had incontinence episodes at times. She also stated that the resident called for staff assistance with going to the restroom.</p> <p>An interview with CNA #7 on 07/01/14 at 1:15 PM revealed that Resident #2 was aware when he/she needed to use the restroom and usually rang his/her call light for assistance when she needed help. In addition, CNA #7 stated the resident was offered assistance with toileting every two hours.</p> <p>An interview with the MDS nurse on 07/03/14 at 10:00 AM revealed that when a resident triggered for incontinence, like Resident #2, the resident was placed on a two-hour toileting plan. She stated that they did not assess Resident #2 for patterns of incontinence or develop an individualized plan for Resident #2 to address his/her elimination needs.</p> <p>2. Resident #8 was observed on 07/03/14 at 11:15 AM ambulating in the hallway with the assistance of a walker and two staff members. The resident's sister was observed to be pushing a wheelchair behind the staff members.</p> <p>A review of the record for Resident #8 revealed that the facility admitted the resident on 03/20/14 with diagnoses that included dementia and a fractured femur. The admission MDS dated 03/27/14 revealed that Resident #8 had a BIMS score of 6, which indicated cognitive deficits. Resident #8 was also assessed to be frequently incontinent of urine and bowel. A review of the CAA summary dated 03/27/14 revealed Resident</p>	F 279		

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F 279	<p>Continued From page 9</p> <p>#8 was frequently incontinent of bowel and bladder, and that he/she was toileted before and after meals. The "Assessment for Bowel and Bladder Training," dated 03/20/14 revealed the facility assessed Resident #8 as being "unable to recognize the urge to urinate or defecate" due to a diagnosis of Alzheimer's dementia.</p> <p>The care plan for Resident #8 stated that the resident was frequently incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. The interventions were to toilet the resident before and after meals, utilize adult briefs, and monitor for signs and symptoms of infections.</p> <p>An interview conducted on 07/03/14 at 12:18 PM with direct care staff, CNA #1, revealed that Resident #8 often asked to go to the restroom and recognized the urge to go. CNA #1 further stated that the resident was both incontinent and continent at times.</p> <p>An interview with the MDS nurse on 07/03/14 at 10:00 AM revealed that when a resident triggered for incontinence, they were placed on a two-hour toileting plan. She stated that they did not assess Resident #2 and Resident #8 for patterns of incontinence or develop an individualized plan to address Resident #2 and Resident #8's elimination needs.</p> <p>3. A review of the facility's "Fall Policy," dated 08/16/13, revealed that after a resident fall occurred, a Fall Risk Evaluation and a Fall Assessment must be completed by the nurse and upon completion of the Fall Risk Assessment and a Fall Assessment, an intervention would be initiated.</p>	F 279			

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F 279	<p>Continued From page 10</p> <p>A review of the facility's "Comprehensive Care Plans" policy, not dated, revealed a care plan would be developed for each resident with measurable objectives to meet the resident's medical, nursing, and psychological needs. The policy also stated care plans were revised as changes in a resident's condition dictated.</p> <p>On 07/01/14 at 9:45 AM and 07/02/14 at 10:15 AM Resident #2 was observed ambulating in the hallway with the assistance of a walker and one staff member. An interview conducted with Resident #2 on 06/30/14 at 3:05 PM revealed the resident sustained falls due to attempting to get up without assistance because the resident needed to go to the restroom.</p> <p>Record review revealed that Resident #2 was admitted to the facility on 12/18/13 with diagnoses that included coronary artery disease, anemia, difficulty walking, muscle weakness, and syncope.</p> <p>A review of Resident #2's comprehensive Minimum Data Set (MDS) assessment dated 12/15/13 revealed the facility assessed Resident #2 to have a BIMS score of 13, which indicates no cognitive impairment. The facility identified the resident had sustained a fall in the last month prior to admission without fracture. The Care Area Assessment (CAA) summary for falls dated 12/31/13 revealed Resident #2 was non-ambulatory and utilized a wheelchair for mobility. The CAA summary for urinary incontinence dated 12/31/13 stated that Resident #2 was incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes.</p>	F 279			

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

PRINTED: 07/18/2014
FORM APPROVED
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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 07/03/2014
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 279	<p>Continued From page 11</p> <p>The quarterly MDS assessment that was completed on 06/16/14 for Resident #2 revealed the facility assessed Resident #2 to require extensive physical assistance from one person for transfers and ambulation. The MDS from 06/16/14 revealed the facility also assessed the resident as always being incontinent of urine and bowel, and to have had two or more falls without injury since the previous assessment.</p> <p>A review of the care plan for Resident #2 dated 01/03/14 and updated 04/03/14, revealed the facility identified the resident had problems including urinary incontinence and a risk for falls. The approach was to assist the resident to toilet before and after meals. The care plan also stated that Resident #2 had a history of falls and the goal was for the resident to have no injuries from falls by the next review. The approaches included assisting the resident with bed mobility and transfers as needed.</p> <p>Further review of Resident #2's record revealed the resident had sustained eight falls since admission to the facility (01/28/14, 02/14/14, 02/23/14, 03/03/14, 03/12/14, 03/14/14, 04/22/14, and 06/16/14). A review of the incident reports for each of the falls revealed that the resident was trying to get up unassisted during each of the incidents, however, the facility failed to address why the resident was attempting to get up unassisted.</p> <p>Further review of Resident #2's care plan revealed no evidence the resident's care plan was revised with fall interventions since the care plan was initially developed on 01/03/14, even though the resident had sustained eight falls</p>	F 279			

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

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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 279	<p>Continued From page 12 since the care plan was initiated.</p> <p>An interview with the Quality Assurance (QA) nurse on 07/03/14 at 9:00 AM revealed that the Interdisciplinary Team (IDT) met to discuss Resident #2's falls. He stated that he followed up on falls sustained by the resident, tracked all falls in the facility as part of QA, and tried to determine the cause of falls. He stated that he had determined that Resident #2's falls were due to the resident's refusal to request help and the need to be independent. He stated that the resident was on a toileting plan that all residents of the facility were on (toileting every two hours), but the facility had not developed an individualized toileting plan for Resident #2 to assure that he/she did not get up unassisted to go to the restroom in an attempt prevent falls.</p> <p>4. Review of Resident #6's medical record revealed the facility admitted the resident on 05/24/13 with diagnoses that included Alzheimer's disease, dementia, and failure to thrive. Review of the quarterly Minimum Data Set (MDS) assessment dated 05/23/14, revealed Resident #6's BIMS score was 4, which indicated the resident's cognition was severely impaired.</p> <p>Review of the Hospice Contract titled, "Contract for Services Between Hospice Care Plus, INC. and Telford Terrace," dated 2009, revealed the Plan or Hospice Plan would include a detailed description of the scope and frequency of hospice care, services, equipment, therapies, and supplies to be provided by Hospice and to meet the resident's needs. Further review of the policy revealed both Hospice and the facility in conjunction with one another would develop the Plan for each Hospice patient, and the Plan would</p>	F 279			

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

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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 279	Continued From page 13 be updated by Hospice two times per month. A review of Resident #6's care plan dated 09/13/13 revealed no evidence that a plan of care for Hospice had been developed for Resident #6. Interview with the Hospice Nurse on 07/03/14 at 3:45 PM revealed she was the nurse who provided Hospice services for Resident #6. She stated she saw Resident #6 once a week and a Certified Nurse (CNA) visited the resident twice a week. The hospice nurse stated a care plan was completed weekly, but she did not check the resident's medical record to ensure a copy of the care plan was on the chart. The Hospice nurse stated she usually talked with nursing staff when at the facility. Interview with the MDS Coordinator on 07/03/14 at 3:15 PM revealed she was responsible for developing the care plan for each resident. She stated Hospice did not contribute to residents' care plans and only participated in a resident's care plan meeting if they had concerns. Interview with the Director of Nursing (DON) on 07/03/14 at 3:50 PM revealed she had not been monitoring to ensure Hospice care plans were in the medical record. The DON stated the care plan should have been in the resident's chart.	F 279			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1) On 07/03/2014 the Director of Nursing (DON) reviewed resident #2 and #8 entire medical records and identified that no adverse outcome was noted from this deficit practice. Resident #2 and #8 have been referred to therapy for participation in urinary incontinence program to improve and maintain Cont'd		

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 14</p> <p>catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined that the facility failed to ensure that appropriate treatment and services were provided for two (2) of ten (10) sampled residents (Residents #2 and #8) to prevent urinary tract infections and promote as much normal bladder function as possible. The facility assessed Resident #2 and Resident #8 to be incontinent of bowel and bladder. However, a review of the resident's record revealed that he/she was often continent. Resident #8 had a bowel and bladder assessment that stated that he/she was occasionally incontinent, but was unable to participate in a program due to the inability to recognize the urge to urinate or defecate. Record review and interview revealed that Resident #8 was often continent of bowel and bladder. The facility failed to assess Residents #2 and #8 for individualized continence needs and develop an individualized care plan to address Resident #2 and #8's continence needs to maintain bowel and bladder function (refer to F272, F279, and F323).</p> <p>The findings include:</p> <p>1. A review of the facility's "continence program" (no date) revealed the facility was to assess each resident's elimination status and develop an appropriate care plan and interventions within</p>	F 315	<p>F 315 Cont'd</p> <p>current functional status. Nursing staff will utilize the urinary diary to record daily toileting pattern. Pelvic floor exercises will be completed 5 times a week times 4 weeks, if unsuccessful alone will implement e-stim times 4 weeks along with exercises. The goal for urinary incontinent program is to decrease the episodes of urinary incontinence.</p> <p>2) On 07/10/2014 all residents were audit to evaluate appropriateness for interventions or retraining related to current bowel and bladder assessment. No other residents were identified to have been affected by this deficit practice.</p> <p>3) On 07/17/2014 MDS staff and all licensed nursing staff was in-serviced with sample scenarios by the DON and Quality Assurance (QA) Nurse regarding appropriateness for interventions or retraining related to current bowel and bladder status with return verbal understanding noted. Revision of bowel and bladder assessment form to include monitoring number of continent and incontinent episodes within a seven day window. If resident with any continent episodes within that window, they will be referred to the Urinary Incontinence Program.</p> <p>Cont'd.</p>		

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

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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	
F 315	<p>Continued From page 15 seven to ten days after admission.</p> <p>Resident #2 was observed on 07/01/14 at 9:45 AM and 07/02/14 at 10:15 AM ambulating in the hallway with the assistance of a walker and one staff member. An interview conducted with Resident #2 on 06/30/14 at 3:05 PM revealed that the resident was aware when he/she needed to urinate or have a bowel movement and sometimes called out for assistance to go to the restroom and was told by staff that he/she had to wait. The resident stated that it was most often after meals that staff did not answer call lights timely. Resident #2 stated that usually when he/she was trying to get up without assistance, it was because he/she needed to go to the restroom.</p> <p>Record review revealed that Resident #2 was admitted to the facility on 12/18/13 with diagnoses that included coronary artery disease, anemia, difficulty walking, muscle weakness, and syncope.</p> <p>A review of Resident #2's comprehensive Minimum Data Set (MDS) assessment dated 12/15/13 revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicates no cognitive impairment. The MDS also stated that Resident #2 was frequently incontinent of urine and always continent of bowel. The Care Area Assessment (CAA) summary for urinary incontinence dated 12/31/13 stated that Resident #2 was incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. The quarterly MDS assessment that was completed on 06/16/14 revealed the facility assessed Resident #2 to be always incontinent of urine and always</p>	F 315	<p>Cont'd</p> <p>4) The corrective action will be monitored as follows, on admission the admitting nurse will assess the resident for appropriateness of the Urinary Incontinence Program. During any Minimum Data Set (MDS) assessment the MDS Coordinator and/or MDS Assistant will review residents medical record and assess appropriateness for Urinary Incontinence Program and refer for participation if needed. The Interdisciplinary Team will discuss weekly during the standard of care meeting any changes in all resident's bowel and bladder status. As part of the facilities QA program the QA Nurse will conduct monthly random on going audits of 10% of the current resident census to ensure assessment completed correctly with referral of Urinary Incontinence Program.</p> <p>5) Completion date:</p>	07/17/2014	

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

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1925 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 315	<p>Continued From page 16 incontinent of bowel.</p> <p>Further review of the record revealed that the "Assessment for Bowel and Bladder Training" had been completed on 12/18/13 and again on 03/19/14 and 06/17/14. The 12/18/13 and 03/19/14 assessments stated that the resident was unable to participate in a training program due to weakness and requiring assistance. The plan for management was to toilet the resident before and after meals, at bedtime, and as needed. The 06/17/14 assessment stated that the resident was able to participate in a training plan due to occasional incontinence secondary to weakness and that the resident knew when he/she needed to go to the restroom. The plan for management was to toilet the resident before and after meals, at bedtime, and as needed.</p> <p>A review of the care plan for Resident #2 dated 01/03/14 and updated 04/03/14 revealed the facility assessed the resident to have problems with urinary incontinence. The care plan stated that Resident #2 was occasionally incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. In addition, the care plan stated facility staff would provide perineal care after each incontinence episode and staff would assist the resident with toileting before and after meals. However, a review of the nurse aide assignment sheets for June 2014 revealed that Resident #2 was continent every day.</p> <p>An interview with the direct care staff, CNA (certified nurse aide) #6, on 07/02/14 at 10:00 AM revealed that Resident #2 was often continent, but had incontinence episodes at times. She also stated that the resident called for assistance</p>	F 315			

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

PRINTED: 07/18/2014
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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 07/03/2014
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 315	<p>Continued From page 17 when needing to go to the restroom.</p> <p>An interview with CNA #7 on 07/01/14 at 1:15 PM revealed that Resident #2 was aware when he/she needed to use the restroom and usually rang her call light for assistance when she needed help. In addition, CNA #7 stated the resident was offered assistance with toileting every two hours.</p> <p>2. Resident #8 was observed on 07/03/14 at 11:15 AM ambulating in the hallway with the assistance of a walker and two staff members. The resident's sister was observed to be pushing a wheelchair behind the staff members.</p> <p>A review of the record for Resident #8 revealed that the facility admitted the resident on 03/20/14 with diagnoses that included dementia and a fractured femur. The admission MDS dated 03/27/14 revealed that Resident #8 had a BIMS score of 6, which indicates cognitive deficits. Resident #8 was also assessed to be frequently incontinent of urine and frequently incontinent of bowel. A review of the CAA summary dated 03/27/14 revealed that Resident #8 was alert and oriented with confusion. Furthermore, the CAA summary stated that Resident #8 was frequently incontinent of bowel and bladder, and that he/she was toileted before and after meals. The "Assessment for Bowel and Bladder Training," dated 03/20/14 revealed the facility assessed Resident #8 as being "unable to recognize the urge to urinate or defecate" due to a diagnosis of Alzheimer's dementia. The care plan for Resident #8 stated that the resident was frequently incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. The interventions were to toilet the</p>	F 315			

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

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FORM APPROVED
OMB NO. 0938-0391

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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 315	<p>Continued From page 18</p> <p>resident before and after meals, utilize adult briefs, and monitor for signs and symptoms of infections.</p> <p>An interview conducted on 07/03/14 at 12:18 PM with direct care staff, CNA #1, revealed that Resident #8 often asked to go to the restroom and recognized the urge to go. CNA #1 further stated that the resident was both incontinent and continent at times.</p> <p>On 07/02/14 at 3:27 PM, an interview conducted with the DON (Director of Nursing) revealed that the Assistant Director of Nursing (ADON) or the nurse that admitted the resident completed the "Assessment for Bowel and Bladder Training." The DON reviewed the assessments that had been completed for Resident #2 and Resident #8 and stated that she felt that the staff had incorrectly assessed the residents. The DON stated that the residents should be able to participate in a training or continence program.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 07/03/14 at 9:35 AM. The ADON stated that she usually completed bowel and bladder assessments for the residents of the facility. She stated that residents who were alert and oriented like Resident #2 were not placed on a bowel and bladder training program because they did not need to be "retrained." She stated that they were placed on a toileting plan that every resident in the facility used, which was an every two-hour toileting schedule. She stated that they do not have residents on an individual toilet schedule. The ADON further stated that for Resident #2, it was "not an urgency problem [sudden urge to urinate], but getting her there quick enough."</p>	F 315			

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

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FORM APPROVED
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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 315	Continued From page 19	F 315			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure that residents received adequate supervision to prevent falls for one (1) of ten (10) sampled residents (Resident #2). Resident #2 had a history of falls prior to admission to the facility and the facility assessed the resident to be at risk for falls. However, the facility failed to assess/address Resident #2's toileting needs and the resident sustained eight falls from 01/28/14 through 06/16/14 while attempting to get up unassisted to toilet (refer to F272, F279, and F315).</p> <p>The findings include:</p>	F 323	<p>483.25(H) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>1) On 07/03/2014 the Director of Nursing (DON) reviewed resident #2 entire medical records and identified that no adverse outcome was noted from the deficit practice. Resident #2 previous falls were re-evaluated and in an individualized toileting program was initiated.</p> <p>2) On 07/10/2014 all resident's medical records were reviewed by the DON to evaluate the need for any individualized intervention or programs that would help enhance the resident's safety and wellbeing. No other residents were identified to have been affected by this deficient practice.</p> <p>3) On 07/03/2014 all licensed nursing staff was in-serviced by Quality Assurance (QA) Nurse regarding resident falls and the need for individualized interventions or programs to ensure the residents safety and well-being.</p> <p>Cont'd.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 20</p> <p>A review of the facility's "Fall Policy," dated 08/16/13, regarding falls revealed that after a fall occurred, a Fall Risk Evaluation and a Fall Assessment must be completed by the nurse. Furthermore, upon completion of the Fall Risk Assessment and a Fall Assessment, an intervention would be initiated at that time.</p> <p>Resident #2 was observed on 07/01/14 at 9:45 AM and 07/02/14 at 10:15 AM to ambulate in the hallway with the assistance of a walker and one staff member.</p> <p>Record review revealed that Resident #2 was admitted to the facility on 12/18/13 with diagnoses that included coronary artery disease, anemia, difficulty walking, muscle weakness, and syncope.</p> <p>A review of Resident #2's comprehensive Minimum Data Set (MDS) assessment dated 12/15/13 revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of 13, which indicates no cognitive impairment. The MDS also stated that Resident #2 was frequently incontinent of urine, always continent of bowel, and had sustained a fall in the last month prior to admission without fracture. The Care Area Assessment (CAA) summary for falls dated 12/31/13 stated that the resident was non-ambulatory and utilized a wheelchair for mobility. The CAA summary for urinary incontinence dated 12/31/13 stated that Resident #2 was incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes.</p> <p>The quarterly MDS assessment that was</p>	F 323	<p>F 323 Cont'd</p> <p>4) The corrective action will be monitored as follows, the nurse performing initial assessment on a residents fall will review that resident for an individualized intervention or program to maintain resident's safety and well-being. The QA Nurse or Weekend House Supervisor will review all falls daily to ensure proper individualized intervention or program was put in place and the effectiveness. The Interdisciplinary Team will review all falls weekly to assess the effectiveness of the individualized intervention or program. As part of the facilities QA program the QA Nurse will complete monthly on-going audits on all falls to ensure appropriate individualized intervention or program were put in place and there effectiveness.</p> <p>5) Completion date:</p>	07/17/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 07/03/2014
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 323	<p>Continued From page 21</p> <p>completed on 06/16/14 for Resident #2 revealed the facility assessed Resident #2 to require extensive physical assistance from one person for transfers and ambulation. The MDS from 06/16/14 revealed the facility also assessed the resident as always being incontinent of urine, always incontinent of bowel, and to have had two or more falls without injury since the previous assessment.</p> <p>A review of the care plan for Resident #2 dated 01/03/14 and updated 04/03/14, revealed the facility identified the resident had problems including urinary incontinence and a risk for falls. The care plan stated that Resident #2 was occasionally incontinent of bowel and bladder and utilized adult briefs to manage incontinence episodes. The approach was to provide prompt perineal care after each incontinence episode and to assist the resident to toilet before and after meals. The care plan also stated that Resident #2 had a history of falls and the goal was for the resident to have no injuries from falls by the next review. The approaches included assisting the resident with bed mobility and transfers as needed.</p> <p>Further review of Resident #2's record revealed the resident had sustained eight falls since admission to the facility (01/28/14, 02/14/14, 02/23/14, 03/03/14, 03/12/14, 03/14/14, 04/22/14, and 06/16/14). A review of the incident reports for each of the falls revealed that the resident was trying to get up unassisted during each of the incidents, but did not address why the resident was attempting to get up unassisted.</p> <p>An interview was conducted with Resident #2 on 06/30/14 at 3:05 PM. Resident #2 stated that</p>	F 323			

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

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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 22</p> <p>sometimes he/she called out for assistance to go to the restroom and was told by staff that he/she had to wait. Resident #2 stated that it was most often after meals that staff did not answer call lights timely. Resident #2 stated that usually when he/she attempted to get up without assistance, it was because he/she needed to go to the restroom.</p> <p>An interview with the direct care staff, CNA (certified nurse aide) #6, on 07/02/14 at 10:00 AM revealed that Resident #2 was often continent, but was sometimes incontinent. She also stated that the resident called for assistance to go to the restroom.</p> <p>An interview with CNA #7 on 07/01/14 at 1:15 PM revealed that Resident #2 usually rang his/her call light for assistance when she needed help and that assistance with toileting was offered every two hours.</p> <p>An interview with the Director of Nursing (DON) on 07/02/14 at 3:27 PM revealed that when a resident sustained a fall, the nurse that was working the floor began an assessment and an incident report was completed. The DON stated that the facility has "stand up meetings" on Monday, Wednesday, and Friday of each week to discuss any incidents that have occurred. She stated that a new fall risk assessment was done after each fall and the interdisciplinary team met to review findings. She stated that they try to get to the root cause of the falls.</p> <p>An interview with the Quality Assurance (QA) nurse on 07/03/14 at 9:00 AM revealed that the Interdisciplinary Team (IDT) met to discuss Resident #2's falls. He stated that he followed up</p>	F 323			

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

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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 23 on falls sustained by the resident, tracked all falls in the facility as part of QA, and tried to determine the cause of falls. He stated that he had determined that Resident #2's falls were due to the resident's refusal to request help and need to be independent. He stated that when he spoke to the resident she would always say that she needed to be more independent so he/she could go home. He stated that the resident was on a toileting plan that all residents of the facility were on (toileting every two hours), but the facility had not developed an individualized toileting plan for Resident #2 to assure that he/she did not get up unassisted to go to the restroom in an attempt prevent falls.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure one dietary staff member's beard was covered. Observation of the lunch tray line on 06/30/14 revealed Cook Aide #1 walked in front of the tray line while residents' food trays were being prepared with his beard uncovered.	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY 1) On 06/30/2014 Dietary Manager in-serviced Cook Aide #1 and beard net immediately applied. No resident was identified to have an adverse outcome from this deficient practice. 2) On 06/30/2014 an audit was conducted by the Dietary Manager on all dietary staff to ensure beard nets were being utilized if appropriate. All dietary staff was found to be in compliance. On 06/30/2014 the DON audited all residents to check for adverse outcome related to this deficit practice. No residents were identified to have been affected by this deficit practice. 3) On 07/23/2014 all dietary staff was in-serviced by Dietary Manager on utilizing a beard net at all times while in the kitchen and dining room. The Administrator and Dietary Manager revised the appropriate attire policy on 07/10/2014 to indicate that a beard net must be worn at all times before Cont'd.		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 24 The findings include: Review of the facility policy titled, "Appropriate Attire," dated January 2002, revealed all food service personnel with beards were required to wear beard nets during food serving or preparation. Observation of the lunch tray line on 06/30/14, at 12:03 PM, revealed Cook Aide #1 walked in front of the tray line while residents' food trays were being prepared with no beard cover over his beard. Interview with Cook Aide #1 on 06/30/14, at 12:05 PM, revealed he was unaware he was required to wear a beard cover unless his beard was longer than one inch in length. He stated since his beard was approximately one-half inch long he did not think a beard was required. Interview conducted with the Dietary Manager on 06/30/14, at 12:07 PM, revealed Cook Aide #1 should have worn a beard net when he was in the food preparation and serving area. The Dietary Manager stated he monitored staff for hairnets, beard covers, and hand washing every time he came into the kitchen and had not identified any concerns.	F 371	F 371 Cont'd entering the kitchen and dining room. 4) The corrective action will be monitored as follows: the Dietary Manager will audit all dietary staff to ensure compliance with the appropriate attire policy daily. As part of the facility Quality Assurance (QA) program the QA Nurse will audit all dietary staff on a monthly basis to ensure proper compliance with the appropriate attire policy, including beard nets to be utilized when in the kitchen and dining room. 5) Completion date:	07/23/2014
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 1) On 07/02/2014 the Infection Control Nurse in-serviced Kentucky Medication Aide (KMA) #1 in regards to proper technique and procedure for blood glucose monitoring and cleaning of the glucometer. The KMA #1 completed a return demonstration with no errors noted. No resident was identified to have had an adverse outcome from this deficient practice.	Cont'd

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

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F 441	<p>Continued From page 25</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission</p>	F 441	<p>F 441 Cont'd</p> <p>2) On 07/02/2014 all licensed nursing staff and KMA's were audited to ensure proper technique during blood glucose monitoring and cleaning of the glucometer. No deficit practice was noted. On 07/02/2014 The DON and QA Nurse audited all residents related to this deficit practice. No residents were identified to have been affected by this practice.</p> <p>3) On 07/02/2014 the Infection Control Nurse in-serviced all licensed nursing staff and KMA's related to blood glucose monitoring and cleaning of the glucometer with return demonstration performed. No deficit practice was noted.</p> <p>4) The corrective action will be monitored as follows, the Infection Control Nurse will complete daily audits five times a week, rotating shifts and personnel. The audits will encompass all nurses and KMA's on all shifts to ensure proper technique with blood glucose monitoring and cleaning of the glucometer. As part of the facility Quality Assurance (QA) program the QA Nurse will conduct monthly on-going audits to include every nurse and KMA to ensure proper technique with blood glucose monitoring and cleaning of the glucometer.</p> <p>5) Completion date:</p>	07/07/2014	

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
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F 441	<p>Continued From page 26</p> <p>of disease and infection for one (1) of three (3) unsampled residents (Resident C). Observation during medication administration on 07/02/14, revealed staff failed to utilize gloves when cleansing the blood glucose-monitoring device. In addition, staff failed to wash/sanitize their hands after checking Resident C's blood glucose.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Cleaning of Glucometer," with a revision date of 07/11/11, revealed staff was required to apply gloves prior to cleansing a blood glucose-monitoring device.</p> <p>Review of the facility's policy titled, "Universal Precautions," undated, revealed staff was required to wash/sanitize their hands between resident contacts.</p> <p>Observation of Kentucky Medication Aide (KMA) #1 on 07/02/14, at 11:45 AM, cleansing the blood glucose-monitoring device revealed the KMA was observed cleaning the device with a bleach wipe and was not wearing gloves. KMA #1 was then observed to perform blood glucose monitoring for Resident C. The KMA then removed her gloves after the testing was completed, and failed to wash/sanitize her hands prior to leaving the resident's room.</p> <p>Interview conducted with KMA #1 on 07/02/14, at 12:00 PM, revealed she was aware she should have worn gloves when cleaning the blood glucose-monitoring device and was aware she should have washed/sanitized her hands after performing blood glucose monitoring for Resident C, but was nervous. The KMA stated she had received in-services by the facility on blood</p>	F 441		

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

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F 441	Continued From page 27 glucose monitoring and hand washing. Interview conducted with the Infection Control Nurse on 07/03/14, at 11:25 AM, revealed he had completed a check-off skills list for KMA #1 on 04/24/14, and blood glucose monitoring, cleansing of the blood glucose monitoring device, as well as hand washing had been covered. The Infection Control Nurse stated he also observed a return demonstration and had not identified any concerns. The Infection Control Nurse stated he also randomly observed two to three medication administration observations, which included blood glucose monitoring and had not identified any concerns. Interview conducted with the Director of Nursing (DON) on 07/03/14, at 3:50 PM, revealed she made rounds several times throughout the day to ensure residents were being provided the care they required. The DON stated the Infection Control Nurse was responsible for medication administration observations, which included blood glucose monitoring, and no concerns had been reported to her. The DON stated KMA #1 was required to wear gloves when cleansing the blood glucose-monitoring device, and was required to wash/sanitize her hands after performing blood glucose monitoring.	F 441			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	483.75(I)(1)RESIDENT RECORDS COMPLETE/ACCURATE/ACCESSIBLE 1) On 07/03/2014 the Director of Nursing (DON) reviewed resident #6 and #7 medical record. The residents that were identified had no adverse outcome from this deficient practice. A MDS assessment correction has been completed for the resident #7 and resident #6 hospice notes were added to resident medical record as required.	Cont'd	

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F 514	<p>Continued From page 28</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined the facility failed to ensure two (2) of ten (10) residents' clinical records were complete and accurately documented. Record review of Resident #7's MDS assessments revealed the assessment did not accurately reflect the resident's assessment for assistance with ambulation and transfers relating to mobility devices. Resident #7 was assessed to have a walker; however, the resident had never used a walker. In addition, the facility failed to ensure Resident #8's Hospice notes were on the resident's medical record as required by the facility's Hospice contract.</p> <p>The findings include:</p> <p>1. Review of Resident #7's medical record revealed the facility admitted the resident on 05/23/14 with diagnoses of muscle weakness, shortness of breath, backache, pain in limb/leg, pain in joint/multiple sites, chronic venous stasis, difficulty walking, and peripheral vascular disease. Review of the Significant Change MDS dated 02/20/14 revealed the facility assessed the resident to utilize a walker. Review of a</p>	F 514	<p>F 514 Cont'd</p> <p>2) On 07/10/2014 the DON and Minimum Data Set (MDS) Coordinator reviewed all resident's medical records for accuracy and total compliance. No further deficient practice was identified.</p> <p>3) On 07/03/2014 the Quality Assurance (QA) Nurse in-serviced the MDS staff regarding the accuracy of assessments. On 07/08/2014 the DON, Hospice Supervisor, and Hospice Nurse met to discuss the Hospice contract and maintaining compliance with chart documentation. On 07/14/2014 the QA Nurse in-serviced the Medical Records staff regarding auditing resident's medical records for hospice compliance with chart documentation.</p> <p>4) The corrective action will be monitored as follows; the MDS Coordinator will review all MDS completed for the week, per MDS scheduler to ensure the accuracy of MDS assessments. The medical records staff will review all hospice residents charts weekly to ensure hospice notes are in the residents chart. As part of the facilities QA program the QA Nurse will complete monthly audits on 10% of residents census to ensure accuracy of assessments and hospice chart documentation per hospice contract.</p> <p>5) Completion date:</p>	07/14/2014	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 29</p> <p>significant change MDS dated 05/30/14 revealed the facility assessed the resident to utilize a wheelchair. Review of the Significant Change MDS dated 05/30/14 revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be 15, meaning the resident's cognition was found to be intact.</p> <p>Observation of Resident #7 on 04/23/14 at 4:37 PM revealed the resident standing in front of a wheelchair, unassisted, trying on clothes.</p> <p>Interview with Resident #7 on 07/03/14 at 11:36 AM revealed the resident has always had a wheelchair.</p> <p>Interview with an LPN on 07/03/14 at 12:00 PM revealed the resident has had a few hospitalizations, is alert and in good spirits, has a Foley catheter and leg weakness, and has always been in a wheelchair.</p> <p>Interviews with the MDS Coordinator and the Assistant MDS Coordinator on 07/03/14 at 2:00 PM revealed they were not aware of Resident #7's assessment showing a walker as a mobility device. The Assistant MDS Coordinator stated, "[He/she] has always been a two assist, [he/she] can't use a walker, and [he/she] has never been on a walker. I meant wheelchair; it has been a keystone; [his/her] mobility has not changed within the last year, [he/she] can't walk." The MDS Coordinator stated they would correct the MDS and start reviewing the MDS's with a "third pair of eyes."</p> <p>Interview with the Director of Nursing (DON) on 07/03/14 at 2:22 PM revealed that she was aware that Resident #7 was incorrectly coded on the</p>	F 514			

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F 514	<p>Continued From page 30 MDS under mobility devices.</p> <p>2. Review of the medical record revealed the facility admitted Resident #6 on 05/24/13 with diagnoses that included Alzheimer's disease, dementia, and failure to thrive. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/23/14, revealed Resident #6's BIMS score was 4, which indicated the resident's cognition was severely impaired.</p> <p>Observation of Resident #6 on 07/02/14 at 3:06 PM revealed the resident lying in bed with eyes closed, fall mats to both sides of bed, with a reddish substance noted on the sheet, left hand/arm and sleeve. The call light was noted to be within the resident's reach.</p> <p>Review of the policy titled, "Contract for Services Between Hospice Care Plus, INC. and Telford Terrace," dated July 2009, revealed Hospice agreed to complete visit documentation prior to leaving the facility and make a more comprehensive visit note/care plan revision available within three working days of the visit.</p> <p>Interview with the Hospice Nurse for Resident #6 on 07/03/14 at 3:45 PM revealed she sees Resident #6 once a week but does not check the resident's medical record to ensure hospice notes are on the medical record. She stated she usually talked with nursing staff when at the facility but wasn't aware that the notes were not on the chart.</p> <p>Interview with the Director of Nursing (DON) on 07/03/14 at 3:50 PM revealed she had not been monitoring to ensure Hospice notes were on residents' medical records.</p>	F 514			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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