

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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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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 F 253 SS=E	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted 02/08/11 through 02/10/11 and a Life Safety code survey was conducted on 02/09/11. The facility was found to not meet minimum requirements for recertification and deficiencies were cited with the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This CONDITION is not met as evidenced by: The facility failed to maintain a sanitary and clean environment in the four (4) whirlpools and shower rooms, replace dirty shower curtains, clean and replace missing caulking around the base of toilets, clean the second floor medication room refrigerator, repair frayed wheelchair/Geri chair arm rest. In addition, a spray can of paint and cleaning solutions were found in an unlocked cabinet in the second floor south shower room.</p> <p>The findings include:</p> <p>Observations of the first floor south shower room on 02/08/11 at 2:45pm revealed a brown and black substance on the lower wall and shower flooring at the drain area. The tan whirlpool tub had a grayish substance under the chair lift and around the drainage hole of the tub. Whitish gray</p>	F 000 F 253	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required under the provisions of federal and state law.</p> <ol style="list-style-type: none"> The frayed gerichair arm rest was repaired by environmental services staff. Shower curtains in all four shower rooms were removed, washed and replaced. Caulking was replaced around toilet bases in shower rooms. All four showers and whirlpool tubs were thoroughly cleaned. Cabinet doors in shower rooms are locked when not in use. Residents assigned to each shower room could be affected by these deficient practices. 	3/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

J. M. [Signature] *Administrator* *3/11/11*

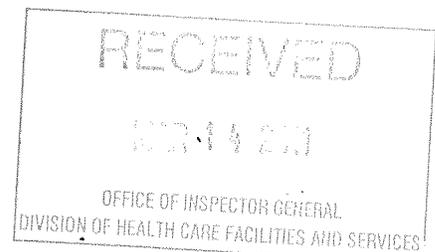
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

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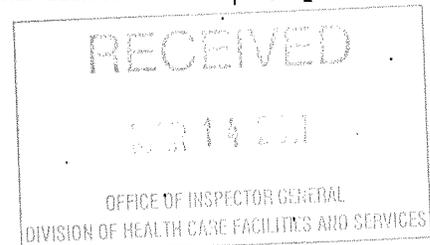
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F 253	<p>Continued From page 1</p> <p>stains were noted under the spicket to the drain. There was a brown substance with an odor on two of the shower curtains.</p> <p>Observations of the first floor north shower room on 02/08/11 at 3:10pm revealed a tan/yellowish ring around the upper part of the whirlpool. Soap stains were noted on the stainless steel backboard shower stall.</p> <p>Interview with Certified Nursing Assistant's (CNA) #6 and #7 on 02/08/11 at 3:30pm revealed the shower rooms are cleaned after each use. A resident was scheduled to have a whirlpool bath the evening of 02/08/11.</p> <p>Interview with CNA's #7, #8, and #9 on 02/10/11 at 2:55pm revealed the whirlpool tubs were to be cleaned after each use.</p> <p>Observations on 02/09/11 at 8:20am revealed the shower room whirlpool tubs, showers, shower stall walls, shower curtains, and shower stall floors had the same substances and stains as seen on 02/08/11.</p> <p>Observations of the second floor south shower room on 02/09/11 at 10:40am revealed brownish/black substances on the shower stall floor tiles and on the lower side walls. A cabinet for shower and tub cleaning solutions was left unlocked and upon inspection a can of spray paint was found.</p> <p>Observations of the second floor north shower room on 02/09/11 at 11:15am revealed brown stains in the upper front left corner of the whirlpool and brown stains on the shower curtains.</p>	F 253	<p>Ambulatory wandering residents could be exposed to the unlocked cabinets and their contents.</p> <p>3. The importance of locking the shower room cabinet when not in use as well as dangers of cans of paint/chemicals sitting out in the open was covered in mandatory inservices for nursing staff on March 15,16,22,or 23, 2011and for Housekeeping and Maintenance staff on March 9, 2011. This information will also be included in unit orientation for new staff. Random checking will be done throughout each day by the unit manager to assure staff is cleaning whirlpool tubs after each bath is given. Instructions for cleaning whirlpool tubs are posted on the wall at the head of each tub. Daily cleaning of showers and weekly cleaning of exterior of whirlpool tubs will be done by housekeeping staff and recorded on the House-</p>	



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F 253	Continued From page 2 Observations in the medicine room on 02/09/11 at 11:20am on the second floor revealed there were yellow stains in the bottom of the medication refrigerator Observations on the medication refrigerator on the second floor on 02/09/11 at 11:25 revealed yellow stains on the bottom of the refrigerator. Interview with nurse #4 revealed there is no routine cleaning schedule for the refrigerator. Review of the AIDE SIGN OUT AND EXTRA DUTY SHEET revealed the staff had initialed off on extra duties for 02/10/11 for the 7am-3pm shift. One of these duties was to clean the whirlpool tub. In addition, record review of the Shower Room Checks Sheet, completed by Maintenance, revealed the list did not include checking for sanitation of the whirlpool tubs, shower curtains, or any substances on the floors or shower stalls. Interview with the Director of Maintenance/Environmental Services on 02/09/11 at 9:10am revealed the whirlpool tubs are to be cleaned by nursing and the shower stalls by environmental services. The director had no explanation for a can of spray paint in the cabinet of the shower area in the second floor south shower stall. The director stated they do replace arm rests that are worn on wheelchairs and Geri chairs. Maintenance had no work orders for repairs of wheelchairs or Geri chairs. Interview with the Administrator on 02/10/11 at 2:10pm revealed nursing had a cleaning schedule for the cleaning of whirlpool tubs; but they had no schedule for cleansing after each use.	F 253	keeping WP Tub and Shower Log posted in each shower room. 4. An analysis of documentation by housekeeping staff will be submitted to the QA&A Committee for their review and recommendations. The Unit Manager will check the shower rooms and documentation on the CNA care guides daily at the end of day shift. Negative findings will be submitted to the QA&A Committee monthly for their review and recommendation. 1. The second floor medication refrigerator was cleaned. 2. All residents could have been affected. 3. A routine cleaning schedule will be initiated for the medication refrigerators on both the second and first floors. 4. A monthly audit of medication refrigerator cleanliness will be conducted and submitted to the QA&A Committee for their review and recommendations.	



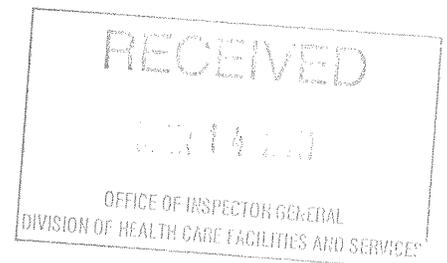
F253/N134

3/24/11

AMENDED POC

3. A routine cleaning schedule will be initiated for the medication refrigerators on both the first and second floors. The 11-7 nurse will check daily to assure that the refrigerator is clean. The 11-7 shift supervisor will assign someone to clean the refrigerator each Sunday. Both will be recorded on the Medication Refrigerator Cleaning Schedule form.

4. The completed Medication Refrigerator Cleaning Schedule form for both the first and second floor refrigerators (100%) will be submitted by the 11-7 Supervisor to the Unit Manager who will submit it to the QA&A chairperson prior to the QA&A meeting for analysis. Findings will be reported to the QA&A Committee. Audits will continue until the QA committee recommends discontinuation or continuation of the audit, based on the findings.



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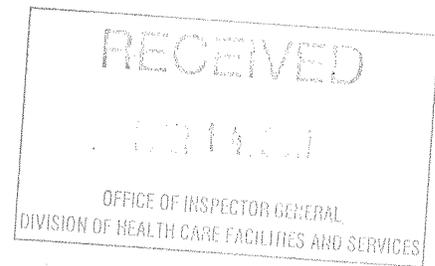
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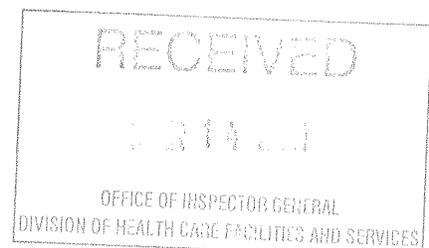
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to review and revise the comprehensive care plan for one (1) of twenty-six (26) sampled residents. On five (5) listed problems or needs on the care plan, the goal and target dates had not been updated to reflect the current status for Resident #12.</p> <p>The findings include: Review of the facility policy on Quarterly Review of Care Plans revealed "The Care</p>	F 280	<ol style="list-style-type: none"> Care plans for resident #12 were updated, Any resident who might have an inaccurate plan of care could be affected by this practice. Updating of care plans will be added as a step to the order transcription procedure, temporary care plans will be available to nurses to address immediate resident needs. Mandatory inservice re: procedures and use of the care plans will be provided to nursing staff on March 16 and 23, 2011. Copies of new orders will go to nursing management for review and then to MDS for care plan updating. An audit will be conducted monthly by the MDS Coordinator of 20 care plans to assure they reflect current status and treatment for the resident. Findings will be submitted to the QA&A Committee for their review and recommendations. 	3/24/11
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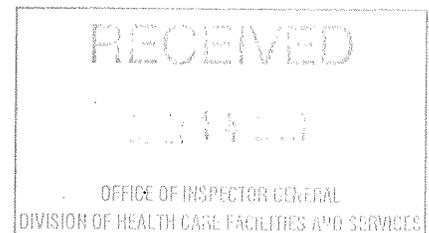
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F 280	<p>Continued From page 4</p> <p>Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status".</p> <p>Review of the most current Minimum Data Set (MDS) dated 11/24/10 revealed the resident was assessed as non ambulatory, requiring assistance in activities of daily living due to Dementia, nutritional status, falls, and behaviors.</p> <p>Review of the comprehensive care plan for Resident #12 revealed the resident was at risk for alteration in Nutrition due to Dementia, anorexia, poor oral intake, and weight loss dated 06/29/10 with a goal date of 09/29/10. The care plan indicated the resident was to receive Remeron, Megace, multiple vitamin, and calcium supplements. However, the resident was not receiving any medications. The care plan addressing potential for injury with a goal date of 03/31/11 indicated the staff were to monitor for side effects of psychotropic medications; however, the resident was not receiving any psychotropic medications. The care plan addressing activities was not reviewed or revised 01/10/11.</p> <p>The behavior care plan addressing refusal of care, and episodes of wandering had been reviewed on 12/23/10; however, it still indicated the resident was receiving psychotropic medications and was ambulatory. The activities of daily living care plan dated 08/22/10 had no goal dates.</p> <p>Interview on 02/09/11 at 12:15pm with Registered Nurse (RN) #1 revealed care plans were updated as needed. RN #1 stated once a month a care plan is completely reviewed by ancillary departments.</p>	F 280	<p>AMENDED POC</p> <ol style="list-style-type: none"> Care plans for resident #12 were updated by the MDS nurse. Any resident who might have an inaccurate plan of care could be affected by this practice. The MDS Coordinator and another nurse will audit all current medical records to assure that the care plan reflects the resident's current condition. If any discrepancies are found the care plans will be revised to reflect the change. Updating of care plans will be added as a step to the order transcription procedure as a step in the admission process to be completed by the nurse, temporary care plans will be available to nurses to address immediate resident needs. Mandatory inservice re: procedures and use of the care plans will be provided to nursing staff on March 16 and 23, 2011. Copies of new 	3/24/11



AMENDED POC 280/N192
CONTINUED

orders will go to nursing management for review and then to the MDS nurse for care plan updating. Activities and Social Service staff will update their portion of the care plans as needed based on their observation and interactions with the residents.

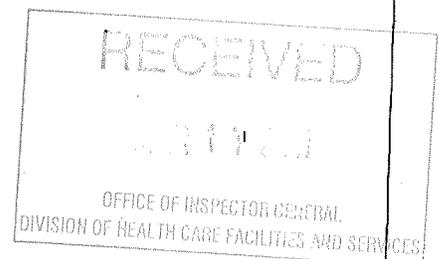
4. An audit will be conducted monthly by the MDS Coordinator of 20 care plans to assure they reflect current status and treatment for the resident. Audits will continue until the QA committee recommends discontinuation or continuation of the audit, based on the findings.



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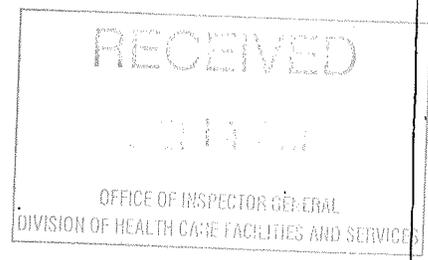
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F 280	Continued From page 5 Interview on 02/09/11 at 3:40pm with the MDS Coordinator revealed care plans were updated on a change or quarterly. Interview on 02/09/11 at 3:32pm with the Director of Nurses revealed the care plans updates were done quarterly or with any change of status.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to follow physician orders for two (2) of twenty-six (26) residents regarding Resident #8 restraints and Resident #9's nutritional supplements. The findings include: Observations made of Resident #8 in a wheelchair on 02/09/11 at 8:10am, 8:16am, 8:30am, 8:42am, 9:10am, 9:22am, 9:30am, 10:00am and 10:45am revealed no trunk restraint was applied during meal time and resting in resident room. Record review of Resident #8's physician order's dated 06/18/10 revealed SR SB to wheelchair.	F 309	1. A soft belt restraint was assigned to Resident #8, CNA Care Guide was updated to include SBR when in wheelchair and to be released every 2 hours X 10 minutes and resident repositioned and skin checked. The order for Resident #9 to have BOOST was properly transcribed and initiated. 2. All residents who had orders transcribed could have been affected by this deficient practice. 3. The importance of communicating with the Unit Manager or Charge Nurse when an order/treatment cannot be completed was addressed in mandatory inservices for nursing staff on	3/24/11



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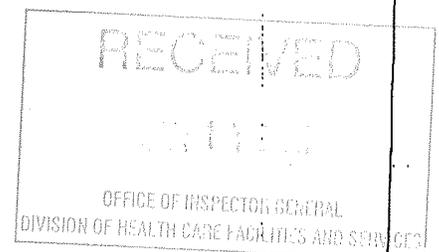
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F 309	<p>Continued From page 6</p> <p>Release every 2 hours x 10 min to reposition and check skin. Record review of the Certified Nursing Assistant (CNA) Daily Care Guide under section "Safety Devices and Appliances" revealed no record of applying soft belt restraint to wheel chair.</p> <p>Interview with CNA #4 on 02/09/11 at 11:09am revealed she was aware that Resident #8 needed to have a soft belt restraint on while in the wheelchair. CNA #4 voiced that she looked for the soft belt restraint, called laundry to see if they had the restraint and looked in the basement. CNA #4 further stated that she did not notify the nurse on the unit that the restraint was missing. If Resident #8 did not have the soft belt restraint on him/her could possibly slide out of the chair onto floor.</p> <p>Interview with CNA #5 on 02/09/11 at 11:10am revealed that CNA's look at the care card when providing care. The soft belt restraint was not on Resident #8's care card.</p> <p>Interview with the Licensed Practical Nurse (LPN) #4 on 02/09/11 at 11:18am revealed that CNA #4 did not make her aware that Resident #8 did not have her soft belt restraint on. The belt is used to remind Resident #8 to not get up without help. LPN #4 further stated if she had been aware that Resident #8 did not have his/her soft belt restraint on, she would have tried to retrieve the item right away.</p> <p>Interview with CNA #3, who functioned as the unit secretary, on 02/09/11 at 5:00pm revealed the unit secretary updated the daily care guide when made aware of the order or if it was conveyed by the nurse. CNA #3 further stated it was ultimately</p>	F 309	<p>March 15,16,22,or 23, 2011 nursing staff. The procedure for Transcription of Orders was reviewed and revised. 4. An audit of transcription of orders will be completed and submitted to the QA&A Committee monthly for their review and recommendations.</p> <p>AMENDED POC</p> <p>1. A soft belt restraint was assigned to Resident #8, CNA Care Guide was updated to include SBR when in wheelchair and to be released every 2 hours X 10 minutes and resident repositioned and skin checked. The order for Resident #9 to have BOOST was properly transcribed and initiated. 2. All residents who had orders transcribed could have been affected by this deficient practice. The Unit</p>	3/24/11



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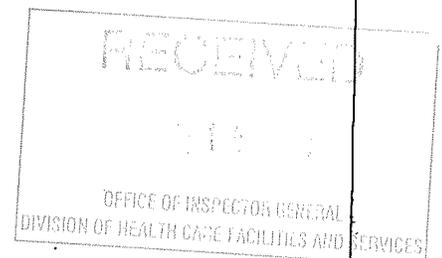
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F 309	<p>Continued From page 7</p> <p>the nurses' responsibility to change care guides.</p> <p>Interview with the 2nd floor Unit Manager RN #1 on 02/09/11 at 8:30am revealed she was not aware that Resident #8 was to have a soft belt restraint on while in the wheelchair. CNA's were trained to notify the manager or nurse when items are missing. Resident #8 could fall or scoot out of wheelchair.</p> <p>Review of the facility policy on Medication Orders revealed enteric orders "will be faxed to the pharmacy, and entered into AHT (American Health Tech Computer System) per AHT guidelines book, to be transcribed to the MAR or TAR. The order will be signed off by an RN or LPN, with his/her name and the date, which indicates that orders are faxed and noted".</p> <p>Review of the physician's orders for Resident #9 revealed on 02/07/11 at 12:35pm an order for the nutritional supplement Boost was ordered to be given with each meal and at night for a snack.</p> <p>Review of the Medication Administration Record (MAR) on 02/08/11, 02/09/11 and 02/10/11 for Resident #9 revealed there was no order for Boost entered into the record.</p> <p>Observation on 02/08/11 in the dining room for the noon meal revealed no Boost was served with the lunch of Resident #9. The breakfast tray on 02/09/11 at 9:30am in the resident's room did not contain Boost. The lunch tray on 02/09/11 at 1:00pm in the resident's room did not include the Boost.</p> <p>Interview on 02/10/11 at 4:05pm with LPN #3</p>	F 309	<p>Managers will complete a 100% audit of restraint and dietary supplement orders, comparing physician orders to care plans for accuracy</p> <p>Discrepancies will be corrected by proper transcription or change of order if necessary.</p> <p>3. The importance of communicating with the Unit Manager or Charge Nurse when an order/treatment cannot be completed was addressed in mandatory inservices for nursing staff on March 15,16,22,or 23, 2011 nursing staff.</p> <p>The procedure for Transcription of Orders was reviewed and revised.</p> <p>4. An audit of transcription of orders for 20% of the residents on each unit randomly selected will be completed monthly by the Restorative/Infection Control Nurse and submitted to the Unit Manager who will forward it to the QA&A Chairperson for submission to the QA&A Committee.</p> <p>Audits will continue until the</p>	



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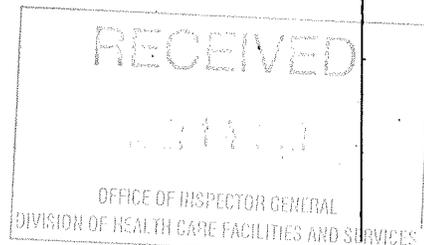
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 revealed new orders received by the physician may take as long as the end of the current shift to be transcribed; however, it would not be days. Interview with Administrative Nurse #3 on 02/10/11 at 3:50pm revealed the person responsible to check the MAR to verify the order is noted would be the nurse taking off the order. Interview on 02/10/11 at 4:02pm with CMT/CNA #2 revealed if the order is not in the computer, placed there when taken off, the CMT would not know to give the Boost.	F 309	QA committee recommends discontinuation or continuation of the audit, based on the findings.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to monitor sharps being left in one (1) of twenty-six (26) sampled residents' bathrooms. A used, disposable razor was left in Resident #5's bathroom for three (3) days. The findings include: Review of the facility's Infection Control Policy and Procedure Manual revealed all sharps must be handled as medical waste, placed in approved	F 323	1. Used disposable razor was removed from bathroom counter of Resident #5 during the survey. 2. Any resident who went into that bathroom could have been affected by this practice. 3. Resident #5 expired on February 26, 2001. This topic will be covered in mandatory inservice for nurses and CNAs on March 15,16,22 or 23,2011 and Housekeeping staff on March 9; remove disposable razors or any sharp objects they find, report this to the unit manager(UM) or charge nurse(CN).	3/24/11



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F 323	<p>Continued From page 9</p> <p>sharps containers, and sent for eventual incineration.</p> <p>Observations on 02/08/11 at 10:55am and 4:00pm, on 02/09/11 at 12:40pm, and on 02/10/11 at 8:05am of Resident #5's bathroom revealed a used, disposable razor laying on the countertop.</p> <p>Interview with CNA #6 on 02/10/11 at 3:30pm revealed that she did not know why the razor was there, how long it had been there, and who it belonged to. CNA #6 stated the razor should be in the sharp's box.</p> <p>Interview on 02/10/11 at 3:40pm with Resident #23 revealed the razor belonged to Resident #5, his/her roommate, and that Resident #5's family member used the razor to shave his/her facial hair. Resident #23 stated the razor had been on the countertop for several days. When questioned if other residents wander into the room, Resident #23 stated that a man recently did wander into the room, but did not go into the bathroom. The resident stated they went out and got the nurse who asked him to leave.</p> <p>Interview with LPN #8 on 02/10/11 at 3:45pm revealed that sharps should be put in a sharp's container and that Resident #5's family members should not leave sharp items out. LPN #8 said that she would inform Resident #5's daughter not to leave razors out. LPN #8 said she would put the razor in the sharp's box so no resident could wander in and be harmed.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p>	F 323	<p>UM or charge nurse will then discuss the issue with appropriate family and remind them of the dangers of bringing such items into the facility and to make the charge nurse aware if they do so.</p> <p>4. Any future similar situations will be reported to the QA&A Committee for review and recommendations.</p> <p>AMENDED POC</p> <p>1. Used disposable razor was removed from bathroom counter of Resident #5 during survey.</p> <p>2. Any resident who went into that bathroom could have been affected by this practice. All staff was advised by the Maintenance Director during the survey process, to observe for razors or any other sharp items lying around in resident or shower rooms and report any findings to the Unit Manager or Charge Nurse.</p> <p>3. Resident #5 expired on February 26, 2001. This topic</p>	3/24/11
F 371 SS=E		F 371		

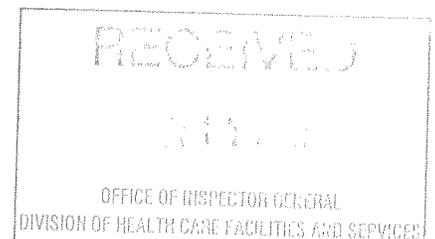


AMENDED POC F323/N219 CONTINUED
will be covered in mandatory inservice for
nurses and CNAs on March 15,16,22 or
23,2011 and Housekeeping staff on March
9; remove disposable razors or any sharp
objects they find, report this to the unit
manager(UM) or charge nurse(CN).

UM or charge nurse will then discuss the
issue with appropriate family and remind
them of the dangers of bringing such items
into the facility and to make the charge
nurse aware if they do so.

Sharps containers are being placed in the
four shower rooms.

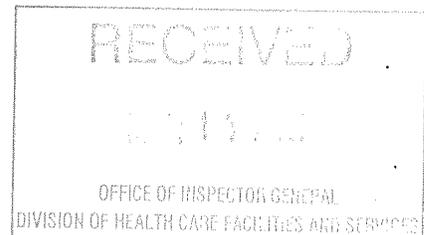
4. Any future similar situations will be
reported to the QA&A chairperson by the
Unit Manager who will discuss the issue
with the QA&A Committee. Audits will
continue until the QA committee
recommends discontinuation or
continuation of the audit, based on the
findings.



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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 371	Continued From page 10 (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 record review, it was determined the facility failed to serve, prepare, and distribute food under sanitary conditions. Opened undated/unlabeled food items were in an uncovered box in the walk-in refrigerator. Two (2) ovens, one (1) mixer, two (2) drawers containing utensils, and the floor were not clean. A scoop was stored in the sugar bin. The concentration sanitation log was not completed for the evening of 02/09/11 and the morning of 02/10/11. Three (3) male dietary staff with facial hair were engaged in the preparation and serving of food without wearing beard restraints. A dietary food server contaminated salads and gelatin desserts by passing over beverages that contained condensation, which dripped water droplets onto the salads and desserts and was served to the residents. A dietary food server observed a resident attempt to remove a salad from a food cart and in the process touched the salad with his/her finger. The dietary food server removed the salad from the resident's grasp, placed it back onto the cart, which was then served to another resident. The findings include:	F 371	1. No resident was affected by the practice. 2. All residents had the potential to be affected by this practice. 3. New procedures were written as follows: * Sanitation and Infection Control * Food Preparation and Handling * Handling of Leftover Food * Date marking * Dress Code and Personal Hygiene * Cleaning Schedules All dietary staff were inserviced about the new procedures and their purpose on March 18, 2011. The ovens were cleaned and de-greased; the floor was deep cleaned; total dietary department and equipment was cleaned. 4. A daily audit for cleaning will be conducted by the Food Service Director, a monthly audit of sanitation,	3/24/11



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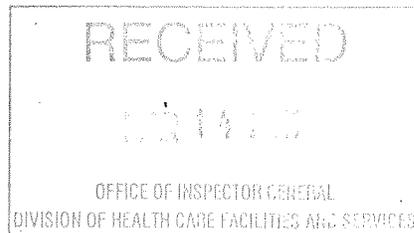
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F 371	<p>Continued From page 11</p> <p>Review of the policy for the prevention of cross contamination revealed food shall be handled using a HACCP process in accordance with regulatory guidelines. Review of the policy for Sanitation and Infection Control/Area and Equipment Cleaning Frequency and Schedules revealed "a cleaning frequency is determined for all areas and equipment in the Food and Nutrition Services Department/Dining Service. An Area and Equipment Cleaning Frequency listing serves as the basis for assignment of cleaning duties to staff, and sanitation inspections." Review of the policy revealed "hair restraints and beard/mustache restraints must be worn to effectively keep hair from contacting food, clean equipment, utensils, linens, and single-service and single-use articles."</p> <p>Observation on 02/08/11 at 8:00am, during the initial tour revealed a box marked "Extra open bags of whatever" in the walk-in refrigerator that contained food items which were not labeled or dated. The box contained meats and vegetables wrapped individually in clear plastic wrappings. Observation on 02/10/11 at 10:00am, during the sanitation tour revealed the items in the box had been dated.</p> <p>Interview with the Executive Chef on 02/08/11 at 8:10am revealed the undated/unlabeled food items in the box were used for cooking. The Executive Chef related the food items were left over from boxes previously opened, and should have been dated.</p> <p>In an interview with the Food Service Director on 02/10/11 at 1:30pm, revealed the facility's policy is that when a product is opened it should be labeled. She admitted the food items in the box</p>	F 371	<p>food distribution and meal service and clinical nutrition by the Dietitian. Both will be submitted to QA&A for review and recommendation.</p> <p>An annual inservice training schedule was developed.</p> <p>AMENDED POC</p> <ol style="list-style-type: none"> 1.No resident was affected by the practice. 2.All residents had the potential to be affected by this practice. All residents were observed by the nursing staff on all shifts, for signs of exposure to contaminated foods. No corrective action was required at this time. 3.New procedures were written as follows: <ul style="list-style-type: none"> *Sanitation and Infection Control *Food Preparation and Handling *Handling of Leftover Food *Date Marking *Dress Code and Personal Hygiene *Cleaning Schedule 	3/24/11
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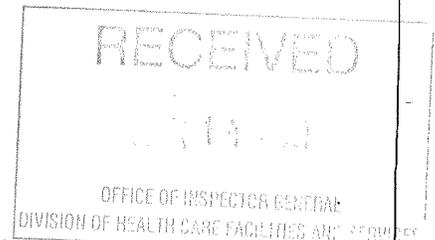
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F 371	<p>Continued From page 12</p> <p>during the initial tour were not dated; however had been dated since. She also stated she could not be sure of the accuracy of the dates given she did not know when the items were opened.</p> <p>Observation on 02/08/11 at 8:00am, during the initial tour revealed two (2) ovens, two (2) utensil drawers, and the floor were not clean. The inside of two (2) ovens was coated with black grime and burnt substance buildup. The utensil drawers contained yellowish and brownish particles. Brown and black substances, dust, and food were on the floor underneath the dishwashing, prep, and salad prep stations.</p> <p>Interview with the Food Service Director on 02/10/11 at 1:30pm revealed the substances on the inside of the oven could be removed with cleaning. She stated the production staff is responsible for cleaning the utensil drawers and the Executive Chef should ensure the task is completed. As to the kitchen floor, she stated it should be "swept and mopped more than once a day." She acknowledged the kitchen had not been cleaned thoroughly on a daily basis.</p> <p>Observation on 02/10/11 at 10:00am revealed a scoop was stored in the sugar bin, One (1) mixer had not been cleaned, and the concentration sanitation log was not completed for the evening of 02/09/11 and the morning of 02/10/11.</p> <p>Interview with the Food Service Director on 02/10/11 at 1:30pm revealed a scoop should not have been stored in the sugar bin. She stated in order to prevent cross contamination it had to be stored in a holder. She also related the staff is trained on the proper storage of scoops and know better than to leave a scoop inside a food bin. In</p>	F 371	<p>All dietary staff were inserviced about the new procedures and their purpose on March 18, 2011.</p> <p>The ovens were cleaned and degreased; the floor was deep cleaned; total dietary department and equipment was cleaned.</p> <p>4. A daily audit for cleaning will be conducted by the Food Service Director or the manager on duty. A monthly audit of sanitation, food distribution and meal service and clinical nutrition will be conducted by the Dietitian. Both will be submitted to QA&A for review and recommendation. An annual in-service training schedule was developed.</p>	



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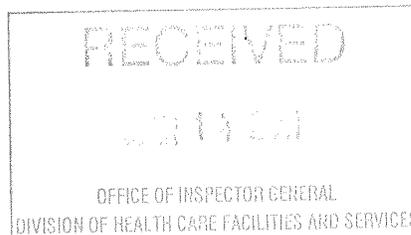
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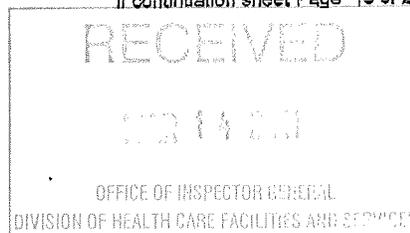
F 371	<p>Continued From page 13</p> <p>regards to the concentration sanitation log having not been signed off, there is no way of knowing if the sanitizer is of the right concentration. According to the Food Service Director, the hostesses are to prepare the sanitizer solution used to wipe down surfaces. After inspecting the mixer, she admitted it had not been cleaned. She stated if surfaces and equipment are not cleaned properly it could lead to cross contamination.</p> <p>Interview with Sous Chef #2 on 02/10/11 at 10:00am revealed she used the mixer on the morning of 02/10/11. She admitted she did not clean food splatter from the mixer using soapy water and sanitizer per policy.</p> <p>Observations on 02/09/11 at 12:25pm during the noon meal in the second floor kitchen revealed Server #6 repeatedly picked up iced beverages and passed them over salads and desserts; whereby, water droplets fell into the uncovered food. The salads and desserts were then served to residents.</p> <p>Observation on 02/09/11 at 12:40pm revealed a resident in a wheelchair rolled up to the salad and desserts cart, reached up and began to drag a salad across the cart. In the process, the resident touched the salad with his/her finger. Server #6 removed the salad from the resident's hand and placed it on the cart. The salad was then served to another resident.</p> <p>Interview with Server #6 on 02/09/11 at 12:35pm revealed she had been employed with the facility for one month. She stated when hired she attended orientation but did not recall any training on cross contamination and food handling. She admitted that water dripping from the bottom of</p>	F 371		
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F 371	<p>Continued From page 14</p> <p>beverages into food was not a good idea.</p> <p>Interview with the Assistant Food Service Director on 02/10/11 at 9:30am revealed water dripping from beverage containers was unsanitary and presented the opportunity for cross contamination. He stated food on the serving line that had been contaminated must be discarded.</p> <p>In an interview with the Food Service Director on 02/10/11 at 1:30pm revealed the actions of Server #6, on 02/09/11 during the noon meal, were inappropriate and did not adhere to policy.</p> <p>Observations on 02/09/11 at 12:00pm and 02/10/11 at 10:00am, revealed three (3) male dietary staff with facial hair not wearing beard coverings and participating in the serving and preparation of food.</p> <p>Interview with Server #7 on 02/10/11 at 2:00pm revealed he does not wear a beard cover while serving food. Interview with Team Leader #9 on 02/10/11 at 2:05pm revealed he was not aware of beard covers. He acknowledged having uncovered facial hair could result in hair getting into the food causing contamination.</p> <p>The Food Service Director in an interview on 02/10/11 at 1:30pm stated she was aware the male dietary staff with facial hair was required to wear a beard restraint per the facility policy.</p> <p>Interview with the Administrator on 02/10/11 at 2:35pm revealed she is aware that the kitchen sanitary conditions are not where they should be.</p>	F 371	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	



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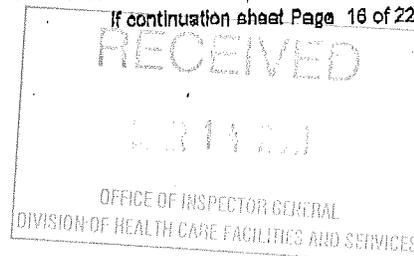
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F 431	<p>Continued From page 15</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug 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, interview, and record review it was determined the facility failed to ensure drugs and biologicals used in the facility</p>	F 431	<ol style="list-style-type: none"> 1. All heparin flushes, bottle of Stomadhesive and 19 cans of expired 2 cal HN were removed from the first floor medication room during the survey. 7 cans of expired Jevity and 8 cans of expired Glucerna were removed from the basement storage room during the survey. 2. Any resident who received any of these products had the potential of being affected by this deficient practice. 3. The procedure re: storage (including checking expiration dates) of all IV medications and supplies, dietary supplements and treatment supplies was reviewed, revised, inservice to nursing staff through mandatory inservice on March 15, 16, 22 or 23, 2011 and implemented. 4. An audit for expiration dates and product packaging will be conducted monthly and findings submitted to the QA&A Committee for review and recommendations. 	3/24/11
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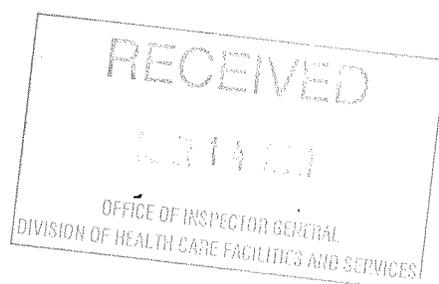
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F 431	<p>Continued From page 16</p> <p>were monitored for expiration dates in one (1) of two (2) medication rooms and in the central supply storage room as evidenced by expired pre-filled heparin flushes and stomachhesive powder found in the first floor medication room and expired tube feeding found in the first floor medication room and in the central supply storage area.</p> <p>The findings include:</p> <p>Record review of the facility's policy for Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles dated 12/01/07 revealed that the facility should ensure drugs and biologicals: (1) have an expired date on the label; (2) have been retained no longer than recommended by manufacturer or supplier guidelines; or (3) if contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier.</p> <p>Record review of the facility's policy for Medical Supply Stock and Rotation dated 02/10/11 revealed that all medical supplies will be controlled and maintained in an accessible manner and rotated according to date, time and shelf life.</p> <p>Observation of the first floor medication room on 02/09/11 at 11:25am revealed four (4) opened boxes, each containing thirty (30) prefilled heparin flush syringes which had expired 11/2010, a large zip top bag containing fifteen (15) prefilled heparin flush syringes which had expired 06/2010, a box containing eleven (11) prefilled heparin flush syringes which had expired 01/2011, one bottle of stomachhesive powder which had expired 08/2010, and nineteen (19) cans of</p>	F 431	<p>AMENDED POC</p> <ol style="list-style-type: none"> 1. All heparin flushes, bottle of Stomadhesive and 19 cans of expired 2 cal HN were removed from the first floor medication room during the survey. 7 cans of expired Jevity and 8 cans of expired Glucerna were removed from the basement storage room during the survey. 2. Any resident who received any of these products had the potential of being affected by this deficient practice. There are no residents on the units with IVs, tube feedings or ostomies at this time. 3. The procedure re: storage (including checking expiration dates) of all IV medications and supplies, dietary supplements and treatment supplies was reviewed, revised, inserviced to staff through "On the Spot" and implemented. 	3/24/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

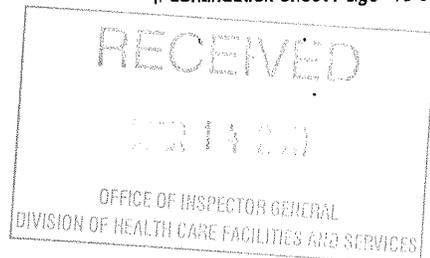
PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 431	<p>Continued From page 17</p> <p>2cal HN tube feeding, including one can that was dented, had expired on 02/01/2011.</p> <p>Record review of residents' receiving tube feeding on 02/10/11 at 3:00pm revealed two (2) residents received Jevity 1.5 and two (2) residents Glucerna 1.2.</p> <p>Observation of the Central Supply storage area on 02/09/11 at 3:55pm revealed one (1) can of Jevity 1.5 on the shelf which had expired on 06/01/08, an eight (8) count case of Glucerna 1.5 tube feeding bottles which had expired on 12/01/10, and an eight (8) count case of Jevity 1cal tube feeding bottles which had expired on 02/01/11.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 02/09/11 at 11:30am revealed that using an expired heparin flush could cause harm to the resident due to unknown toxicity of the medication. Using outdated tube feeding could make the residents ill, and a dented can of tube feeding could harbor bacteria or contain shards of metal.</p> <p>Interview with LPN #6 on 02/09/11 at 11:35am revealed that everyone is responsible for checking the dates on supplies in the medication room but states she is responsible for ensuring dayshift staff are checking the supplies in the medication room. The LPN also stated that she was not sure what could happen to the residents by using expired medications and tube feeding, but she was sure it would make them sick.</p> <p>Interview with the Director of Nursing (DON) on 02/09/11 at 12:00pm revealed that she was not aware who delivers tube feeding to the</p>	F 431	<p>4. A onetime audit for expiration dates and product packaging will be conducted by the Restorative/Infection Control Nurse of 100% of the IV supplies and dietary supplements in the medication room. A monthly 5% audit of the total number of different products will be conducted of products in the medical supply storage room in the basement. Findings will be submitted to the QA&A chairperson. Audits will continue until the QA committee recommends discontinuation or continuation of the audit, based on the findings.</p>	
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
(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 431	<p>Continued From page 18</p> <p>medication room or who checks the dates for expiration. She was also not aware of who supplies prefilled heparin flushes or who is responsible for checking stock.</p> <p>Interview with the Assistant Director of Maintenance on 02/09/11 at 3:55pm revealed that the maintenance department had been in charge of ordering tube feeding supplies for six months. He also stated that all tube feeding that had expired, or is not currently being used by a resident should be sent back to the supplier.</p> <p>Interview with the Director of Maintenance and Environmental Services on 02/09/11 at 4:10pm revealed that since the department had started ordering tube feeding they have utilized the First In First Out method to rotate items. He also stated that expiration dates are checked as the items are stocked and when they are pulled for the floors. He confirmed he did not know expired items were in stock or how they were overlooked. He also explained a recent problem with the nursing staff returning items to the central supply storage room without informing the maintenance staff.</p> <p>Interview with the DON on 02/09/11 at 4:15pm revealed that the facility had not had a resident with an intravenous line for "years" and not sure why there was heparin flush in the medication room. She confirmed there is no system in place for monitoring the medication room for supplies and expiration dates. She also confirmed the potential harm to the resident by using expired medications and biologicals.</p> <p>Interview with the Administrator on 02/09/11 at 4:30pm revealed that a pharmacy audit is</p>	F 431		



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

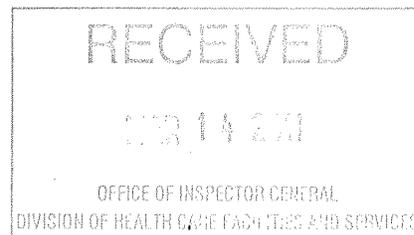
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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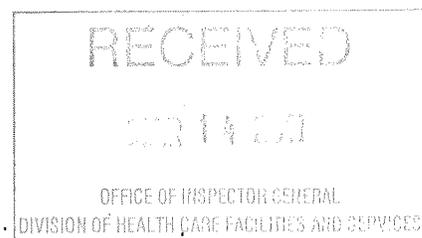
F 502	<p>Continued From page 20 for expiration dates.</p> <p>Observation of the second floor medication room on 02/09/11 at 10:10am revealed a lab specimen refrigerator which did not contain a thermometer. There was no log posted of previous temperatures and the facility could not produce a log of any temperatures of the lab refrigerator. The lab supply cabinet contained the following expired items: twelve (12) purple top tubes which expired 01/2011, two (2) purple top tubes that expired 05/2009, one (1) red top tube that expired 06/2010, two (2) black/red top tubes that expired 09/2010, two (2) green top tubes that expired 12/2010, one (1) yellow top tube that expired 02/2010, eight (8) blue top tubes that expired 06/2010, two (2) blue top tubes that expired 11/2009, and one (1) blue top tube that expired 01/2011. Also expired was a forty-eight (48) count box of vacutainer's dated 12/2009, a blood culture kit dated 12/31/09, three (3) para-pak specimen kits dated 10/2010 and an eclipse needle dated 11/2009.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 02/09/11 at 10:30am revealed that each person is responsible for checking the date of lab supplies before they are used. The LPN confirmed that using expired lab vials would cause incorrect lab results, which could delay or cause inappropriate treatment. She also confirmed that using expired needles could place the resident at risk for an infection.</p> <p>Interview with Registered Nurse (RN) #1 on 02/09/11 at 10:30am revealed that the night shift is responsible for monitoring the medication room and checking the temperature on the refrigerator, but everyone is responsible for checking dates on</p>	F 502	<p>4. A weekly audit will be conducted re: dates on lab supplies and lab refrigerator temperatures. Findings will be submitted to the QA&A Committee for review and recommendations.</p> <p>AMENDED POC</p> <p>1. The expired lab supplies were removed from the lab refrigerator and the temperature was checked by the Restorative/Infection Control Nurse during the survey process.</p> <p>2. Any resident who was tested using one of the expired collection tubes, etc. had the potential to be affected by this practice. The lab provider, LabCorp, has a policy that any specimen sent to them in an expired container will be destroyed and the facility staff will be asked to send a new specimen. Only stats and weekend specimens are drawn by facility staff. There have been no rejections from the lab.</p>	3/24/11
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 502	<p>Continued From page 21</p> <p>the lab equipment. She was not aware that there was neither a thermometer in the refrigerator, nor any evidence of a temperature log. She states there is no current system in place to monitor the lab supplies or the lab refrigerator temperature. She confirms using expired equipment could cause incorrect lab values, which could potentially lead to inappropriate treatment. Expired needles could cause infection, or potentially interact with the medications.</p> <p>Interview with the Director of Nursing (DON) on 02/09/11 at 4:15pm revealed that there is no system in place to monitor for expired lab items or to monitor the temperature of the lab refrigerator. She confirms that using expired lab supplies and storing lab specimens in a refrigerator that is not being monitored for temperature could lead to inaccurate results causing wrong diagnosis and treatment.</p> <p>Interview with the administrator 02/10/11 2:45pm revealed that she was not aware there was not a thermometer in the lab refrigerator and no evidence of temperature logs. She was also not aware there were expired lab supplies. She confirms there is currently no system in place for monitoring supplies for expiration dates and temperature logs. She confirms that she is ultimately responsible for ensuring the effectiveness of laboratory services provided by the facility.</p>	F 502	<p>3. Systems were developed for checking dates on lab supplies weekly by the night shift charge nurse and daily monitoring of the refrigerator temperature by the 11-7 charge nurse.</p> <p>4. The 11-7 charge nurse will conduct a weekly audit re: dates on all lab supplies (100%) and daily check of the lab refrigerator temperature and record them on the audit forms and submit them to the Unit Manager. Findings will be submitted by the Unit Manager to the QA&A Committee. Audits will continue until the QA committee recommends discontinuation or continuation of the audit, based on the findings.</p>



HOUSEKEEPING STAFF
Shower and Whirlpool
Tub Cleaning Schedule

Month/Year

- 1. Shower will be cleaned daily
- 2. Exterior of whirlpool tub will be cleaned weekly
- 3. Place initials in the correct column after you clean the shower or tub.

DATE	SHOWER CLEANED	WHIRLPOOL EXTERIOR CLEANED	
1		X	
2			
3		X	
4		X	
5		X	
6		X	
7		X	
8		X	
9			
10		X	
11		X	
12		X	
13		X	
14		X	
15		X	
16			
17		X	
18		X	
19		X	
20		X	
21		X	
22		X	
23			
24		X	
25		X	
26		X	
27		X	
28		X	
29		X	
30			
31		X	

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 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

MEDICATION REFRIGERATOR CLEANING SCHEDULE

FLOOR _____

MONTH/YEAR _____

1. The 11P – 7A nurse will check daily to assure that the refrigerator is clean.
2. The 11P – 7A shift supervisor will assign someone to clean the refrigerator each Sunday.
3. The person completing task stated in 1 o2 will put their signature in the appropriate block.
4. The Unit Manager will submit this completed form to the QA&A chairperson by the 3rd of each month.

DATE	CLEAN Y or N	CLEANED	COMMENTS
1		X	
2			
3		X	
4		X	
5		X	
6		X	
7		X	
8		X	
9			
10		X	
11		X	
12		X	
13		X	
14		X	
15		X	
16			
17		X	
18		X	
19		X	
20		X	
21		X	
22		X	
23			
24		X	
25		X	
26		X	
27		X	
28		X	
29		X	
30			
31		X	

7280

Procedure for transcribing a physician's order:

When the MD writes a new order, the page which he has written the order on is folded over to the side. This alerts the nurse that there is an order that needs to be noted

The nurse reads and reviews the order.

The unit secretary is notified of any labs or appointments that need to be made, and if applicable, arranges transportation, fills out the necessary forms, makes calls and puts appointments on the calendar.

The nurse enters the order into the AHT computer system so that the order fires to the eMAR / eTAR as follows.

The nurse logs in to the AHT system

The nurse goes to the main menu, then chooses clinical, then chooses physicians orders

The correct resident is chosen from the pull down list or typed into the name section

Order entry is selected, then order type is selected, NDC is selected (this is where the specific drug or treatment is chosen and selected, pay close attention to specifics such as strength, size, form etc.) drug information can be obtained here if you are unfamiliar with the particular medication. This can be used for patient teaching as well if needed.

After you have chosen the correct med or treatment from the NDC category, you may select the interval code (how often is this med going to be given)

Select a time code (what time of day is this going to be given)

Add the supportive diagnosis for the med or treatment

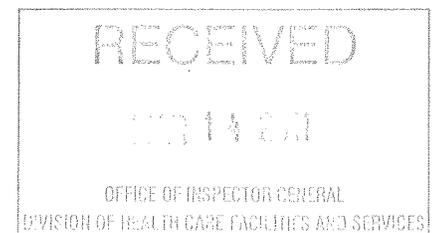
Enter the order date and time

Enter the start date and time

Enter the stop date and time

Enter dc date and time for orders that have been dc

To review eMAR to see if the order shows up as you need it to, go to the main menu, select echart, then eMAR, then select the correct resident, then select go, now you may review what the order looks like on the eMAR or eTAR.



7280

The written physician's order on the chart should now have the time, date, nurse's first initial, last name and title as well as the statement of being "noted". Once the order has been put onto the eMAR, faxed to pharmacy and all persons notified of the new order that are necessary, a note should be made in the residents nurse's progress notes regarding the new MD order with an assessment statement or reason for the order appearing before mentioning the new MD order.

Any time there is a new physician's order to treat a new diagnosis; the residents nursing care plan must be updated to reflect this change in the resident's health condition. Temporary nursing care plans are located in the nurse's station and may be filled out by hand to reflect the new diagnosis. These will be placed on the resident's medical chart.

Physician's orders have carbon copies / duplicate sheets. When a new MD order is written by the MD, has been transcribed/noted by the nurse, and faxed to the pharmacy; a copy of this new order is to be placed in the MDS nurse's mailbox located in the medication room. These copies will then be picked up by the MDS nurse for review and documentation re: care plans and MDS information input.

AHT order types:

Sup supplements
SAF safety device
DBT diabetic
PRD prn diabetic med

TF tube feeding
O2 oxygen
TX treatment
PRT prn treatment

R restraint
MED medication
PRM prn medication

PRN meds and treatments always require a follow up

Mini Nebulizer treatments always require temp, pulse, resp. lung sounds before the treatment, after 15 minutes and after the treatment. The amt of time that it took to administer the treatment has to be documented as well.

Ancillary orders do not fire to the eMAR. When these orders are put into the system, they will appear on the physician's order sheet. i.e diet order change: When a new diet order is written on a physician's order sheet by the MD, the nurse enters the new order into the AHT system. A status report sheet is filled out on the resident by the nurse or the unit secretary. This is the "diet slip". This diet slip has multiple carbons and a copy is given to dietary. A copy is kept by the unit secretary. The unit secretary enters the new diet into the computer in the care plan section so that it will now fire to the Kiosk and the C.NAs will have the most up to date diet order available to them to document on following their daily care delivery. Orders such as low beds, w/c position, special bathing instructions etc. are all entered in this same fashion. These will show up on the Kiosk for C.NA documentation but will not fire to the MAR.

Instructions for changing the diet order on the resident's face sheet to match the current order that is listed in the physicians orders.

7280

The diet order which appears at the bottom of the face sheet, is the diet which the resident came into the facility with (this also appears at the bottom of the physician's order sheets). Diets often get changed to better meet the resident's nutritional needs and health status after admission by the MD.

The diet listed at the bottom of the face sheet must reflect the diet that is listed in the physician's orders. The resident should not have two different diet orders.

When the physician changes a diet order we need to change it in the system in order that the new/current diet appears on the face sheet and at the bottom of the physician's order sheet.

To change the diet on the face sheet and bottom of the physician's orders...

Go to E-chart on the main AHT menu

Enter the resident's name

Choose edit

Resident basic information menu will pop up

Choose other

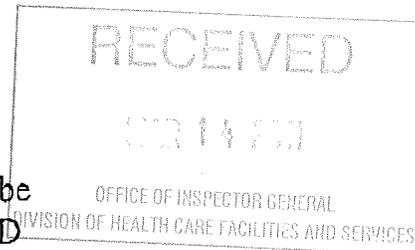
Choose diet- double click

User defined field will pop up.

You are now in the area that the new diet order may be typed to appear on the Face sheet and bottom of MD order.

Type in the order as it appears in the Physician's orders

Click ok- the diet will be changed now on the face sheet and the bottom of the MD order sheets



Lab order procedure:

Once a new lab order is received, it is given to the unit secretary. The unit secretary enters the order into the "Labcorp" computer. Enter the first initial of the resident's last name then scroll down the list until you find the correct resident. Create a lab order. A blue demographics screen will appear. Enter next. Enter the correct ICD-9 code which is the supportive diagnosis to have this test completed. Enter the correct test code. Enter next. Enter collection time as 0600 on all labs. The unit secretary enters her initials. Two copies of the lab requisition sheet will print out. These two copies are stapled together. The lab test is written on the desk calendar for the date that it is due. The nurse is given the physician's order and it is then entered into the AHT system by the nurse. The date that the lab is to be done is entered into the orders. The lab requisition copies are placed into the "Labs to be collected binder". It is important to place these in the binder in numerical order so that they do not appear out of sequence. Once the lab tech has initialed that the lab has been completed, the lab requisition copies go into the accordion file with the sheets placed as to stand up in the file. This alerts the staff that these labs are outstanding and results have not been received as of yet. Once results

are received, the sheets are positioned down in the accordion file and the unit secretary files them after thirty days.

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MARCH 14 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

F371

Cleaning Schedules - Cleaning QA Tool

CLEANING QA				Date:
	AREA CHECKED	S	U	CORRECTIVE ACTION
1	Coffee cart cleaned and filled			
2	Meal tickets updated and current			
3	Dish machine de-limed			
4	Dish room temps (PPM)			
5	Underneath dish machine clean			
6	Microwave clean			
7	Overhead lights working / ceiling clean			
8	Ovens cleaned / shined			
9	Sanitizer buckets filled			
10	3 compartment sinks cleaned / de-limed			
11	3 compartment sinks / temps / PPM			
12	Floors clear of debris			
13	Walk-ins clean / labels / dates			
14	Reach-in cooler / clean / labels / dates			
15	Food prep sink / clean (running water)			
16	Mats / clean / in-place			
17	Condiment rack / clean / filled			
18	Reach-in freezer / temps / clean			
19	Reach-in refrigerator / temps / clean			
20	Coffee / juice area / clean			
21	Food temps / food usage completed			
22	Mop room / clean / organized			
23	Storeroom / clean / organized / labels / dates			
24	Hot cocoa machine clean			
25	Fans / dust free			

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 MAR 14 2011
 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE REGULATION AND SERVICES



F371

Dietary Consultants, Inc.

DIETARY REPORT & MONTHLY QUALITY ASSURANCE AUDIT

Month of: _____ Date: _____ Consultant: _____

Facility: _____ Administrator: _____

Dietary Manager: _____ Hours in Facility: _____

Entrance/Exit Conference (Check box): Admin DON DM Other _____

Dietary Costs per Patient per Day _____ Month Reported _____

Food _____ Paper _____ Chemicals _____ Supplements _____

Comments: _____

Staff Development

In-service schedule available and followed? Yes _____ No _____

List in-service(s) provided this month: _____

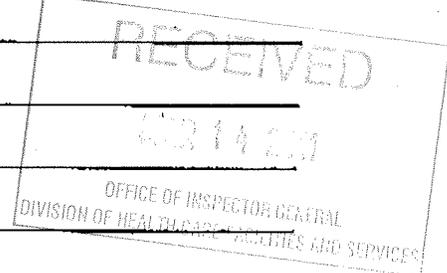
List education needs identified: _____

QUALITY ASSURANCE COMPLIANCE SUMMARY:

I. FOODBORNE ILLNESS RISK FACTORS /SANITATION AUDIT						
# "Yes" answers		1.0	=		points	SCORE (%):
# "No" answers with flags ▶		- 2.0	=		points	
# "No" answers without flags		0.0	=		points	
TOTALS						
II. FOOD DISTRIBUTION/MEAL SERVICE AUDIT						
# "Yes" answers		1.0	=		points	SCORE (%):
# "No" answers with flags ▶		- 2.0	=		points	
# "No" answers without flags		0.0	=		points	
TOTALS						
III. CLINICAL NUTRITION AUDIT						
# "Yes" answers		1.0	=		points	SCORE (%):
# "No" answers		- 1.0	=		points	
TOTALS						

OPPORTUNITIES FOR IMPROVEMENT AND CORRECTIVE ACTIONS

NOTE: FLAGGED (▶) ITEMS "OUT OF COMPLIANCE" ARE TO BE ADDRESSED WITH A SPECIFIC CORRECTIVE ACTION PLAN.





Dietary Consultants, Inc.

F-371

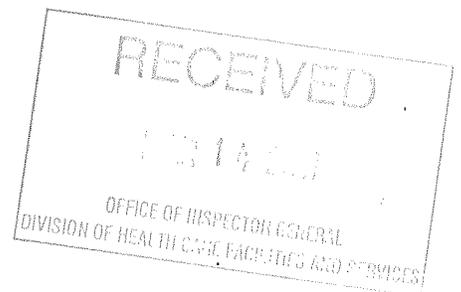
ACCOMPLISHMENTS

Administrator Signature: _____ Date: _____

Director of Nursing Signature: _____ Date: _____

Dietary Manager Signature: _____ Date: _____

Dietitian Signature: _____ Date: _____



F-371



Dietary Consultants, Inc.

I. FOODBORNE ILLNESS RISK FACTORS /SANITATION AUDIT

Facility: _____ Consultant: _____ Date: _____

Quality Indicators		Yes	No	Quality Indicators		Yes	No
I. PURCHASING/RECEIVING				PREPARATION/COOKING (cont.)			
1	DM manages dept. within budgetary guidelines			56	Hood/Vent system/clean/dust free		
▶ 2	Purchases—approved vendors			57	Juice Machine/Nozzle		
3	Purchase/order guide used			58	Coffee Machine(s)/Station		
4	Area clean/dust free			59	Steamer		
5	Delivery invoice; food orders checked in			60	Mixer		
▶ 6	Food received at proper temperatures			61	Food processor		
▶ 7	Food in good condition, safe/unadulterated.			62	Blender		
8	Emergency Food Supply/ Water Contract			63	Slicer		
2. DRY STORAGE				64	Can opener/blade		
9	Clean/dust free/good condition			65	Toaster		
10	Temperature (50°-70° F.)			66	Fryer and baskets		
11	Temperature logged/thermometer accurate			67	Work tables/over/under shelves/drawers		
12	No dented cans			68	Microwave (inside top)		
13	Light fixtures/covers clean/dust free			69	Utensils		
14	Lighting adequate			70	Cutting boards (no wood)		
15	Ingredient containers/ no scoops stored inside			71	Knives (no wood)/rack/stored properly		
16	Shelving clean/dust free			72	Utility carts		
17	Stock dated, rotated, disposed of properly			73	Trash containers/clean/covered		
18	Open ingredients—stored in sealed container			74	Floor/mounted fans/clean/dust free		
19	Items 6" off floor, 18" from ceiling			75	Ice machine/scoop (stored properly)		
20	Chemicals stored separately from foods			76	Steam table clean/free of mineral buildup		
3. REFRIGERATED/FROZEN STORAGE				77	All equipment in good working order; if no, please list:		
21	Refrigerators clean/gaskets in good condition			6. DISHWASHER/POT PAN AREA			
22	Internal thermometer present/accurate			78	Temp/sanitizer recorded each meal		
▶ 23	Items cooled within 6 hrs ≤ 41° F			▶ 79	No cross-contamination (dirty to clean)		
▶ 24	Leftovers disposed per policy			80	Clean/set-up properly/proper chemicals		
25	Light fixtures/covers/clean/dust free			▶ 81	Machine clean/free of mineral buildup		
26	Shelving clean/dust free			▶ 82	Proper sanitizing temp/chemical		
27	Compressor/fan guards clean/dust free			83	Dishes/cups/silverware clean & air dried		
28	Internal Temp. recorded twice daily/appropriate			84	Hood/vent system clean/dust free		
29	Stock dated, rotated			<i>Manual Warewashing</i>			
▶ 30	Leftovers labeled, dated, covered			▶ 85	Proper sanitizing concentration/recorded		
31	Cooked foods stored above raw			86	Pots/pans air dried, stored correctly		
32	Items 6" off floor/ 18" from ceiling			87	Appropriate chemicals		
33	Freezers clean/good condition			88	Chemicals/spray bottles labeled		
34	Internal thermometer present/accurate			89	MSDS available to all during work hours		
▶ 35	Food thawed properly			7. PHYSICAL FACILITIES			
36	Light fixtures/covers/clean/dust free			▶ 90	No visible evidence of insects or rodents		
37	Shelving clean/free from ice buildup			91	Mops clean/stored upright		
38	Compressor/fan guard/clean/dust free/free of ice			92	Dumpster closed, area clean		
39	Internal Temp. recorded twice daily/appropriate			93	Trash containers clean/covered		
40	Stock dated, rotated			94	Trash removed frequently		
▶ 41	Leftovers labeled, dated, covered			95	Floors/clean/free of debris		
42	Items 6" off floor/18" from ceiling			96	Walls/clean/dust free		
43	Door seals; no ice build up on walls/floors			97	Ceilings/lights/covers/clean/dust free		
4. PREPARATION/COOKING				98	Adequate ventilation and lighting		
▶ 44	Food kept out of danger zone (<41 - >140)			8. EMPLOYEES HYGIENIC PRACTICE			
▶ 45	Proper Cooking Time/Temperature			▶ 99	Hand sink(s) accessible and supplied		
▶ 46	Proper reheating for hot holding			100	Hair restraints covering all hair		
▶ 47	Proper cooling Time/Temperature			101	Proper, clean uniform		
▶ 48	Proper cold holding temps			102	Minimum jewelry		
▶ 49	Pasteurized foods used per policy			103	No artificial fingernails, no nail polish		
▶ 50	Fruits/Vegetables properly washed			▶ 104	Gloves properly used/handwashing		
▶ 51	Food-contact surfaces cleaned/sanitized			105	Aprons clean, changed		
▶ 52	Sanitizing towels stored in sanitizing solution			9. DEPT MANAGEMENT/SUPERVISION			
5. EQUIPMENT/UTENSILS CLEAN/SANITIZED/MAINTAINED				▶ 106	DM demonstrates knowledge of duties		
53	Range/Grill top			▶ 107	Management awareness, policies in place		
54	Oven			108	Proper reporting of foodborne illness risks		
55	Thermometers (calibrated)						

▶ Flagged items must be addressed individually with specific action plans.

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 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

F371



Dietary Consultants, Inc.

II. FOOD DISTRIBUTION/MEAL SERVICE AUDIT

Facility: _____ Meal Observed: _____ Date: _____ Time: _____

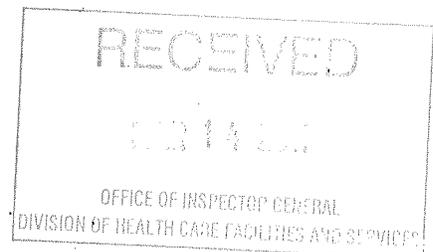
QUALITY INDICATORS		YES	NO	QUALITY INDICATORS		YES	NO
1. TRAY LINE				DINING AREAS CONTINUED			
1	Food on steam table <30 min. before meal			17	Assistive devices provided as ordered		
2	Food held on steam table for < 2 hrs			18	Staff assistance/cueing provided		
▶3	Food temps recorded before service			19	Returned food, unsafe food properly disposed		
▶4	Food temps acceptable			3. TEST TRAY			
▶5	Menu followed for items, portions, diets			▶20	Food items served according to diet order		
6	Diet census accurate			▶21	Tray card accurate for diet, portions, preferences		
▶7	Texture modifications appropriate			▶22	Beverages and Condiments accurate		
▶8	Thickened liquids prepared/served correctly			23	Food preferences honored as written on traycard		
9	Meal attractive/garnished			24	Main Plate Items		
10	Meals palatable			25	Bread/Salad/Dessert		
▶11	Therapeutic diets served accurately			▶26	Temperatures acceptable at point of service		
2. DINING AREA(S)				27	Overall taste and appearance		
12	Dining areas clean/attractive			28	Min. 2 C. Bev. per tray/unless contraindicated		
13	Menu(s) posted; font; at resident eye level			4. SNACKS/SUPPLEMENTS			
14	Table height accommodates wheel chairs			29	Delivered timely		
15	Alternates offered			30	Served timely		
16	Alternates available and accurate			31	Resident food complaints addressed		

TEST TRAY (Point of Service):

Test Tray Delivered to: _____ Time: _____ Elapsed Time From Trayline: _____

Cold Items (<50 at point of service)	Temp	Acceptable		Hot Items (>120 at point of service)	Temp	Acceptable	
		Yes	No			Yes	No

Comments: _____



F-371



Dietary Consultants, Inc.

III. CLINICAL NUTRITION AUDIT

QUALITY INDICATORS		Y E S	N O	NUMBER COMPLETED OUT OF #/ COMMENTS
▶ 1	Consultant recommendations followed up on in a timely manner			
▶ 2	Nutrition assessments up to date (Admissions)			
▶ 3	Nutrition re-assessments up to date (Significant Changes or Annuals)			
▶ 4	Quarterly notes up to date			
▶ 5	Documentation completed on residents with change in health, nutrition, or eating status or those who the consultant has been consulted to see			
▶ 6	Skin breakdown addressed; # of residents w/Pressure Sores _____			
▶ 7	Enteral Feeding addressed # of Enteral Feedings _____			
▶ 9	Notifications from the consultants about new residents at nutritional risk are followed by the IDT			
▶ 10	Facility has protocols for residents at nutritional risk			
▶ 11	Facility follows protocols for residents at nutritional risk			
▶ 12	Facility has protocols for maintaining adequate hydration			
▶ 13	Facility follows protocols for maintaining adequate hydration			
▶ 14	Nutritional concerns reflected in care plans			
▶ 15	Facility provides necessary information: (Heights, weights, skin assessments, etc.)			
▶ 16	Other documentation completed per facility request (specify) _____			

F502/N313

BIOLOGICAL AND LAB SUPPLIES

UNIT _____

MONTH/YEAR: _____

TO BE CHECKED WEEKLY BY THE NIGHT SHIFT CHARGE NURSE

DATE	DATES ON LAB SUPPLIES	SIGNATURE

COMMENTS: _____

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

F502/N313

BIOLOGICAL AND LAB REFRIGERATOR TEMPERATURES

UNIT _____

MONTH/YEAR _____

1. The 11P-7A charge nurse will check and record the refrigerator temperature and his/her signature daily.
2. The unit manager will submit this completed form to the QA&A chairperson by the 3rd of each month.

DATE	TEMPERATURE	SIGNATURE
1		
2		
3		
4		
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29		
30		
31		

F502/N313

BIOLOGICAL AND LAB SUPPLIES

UNIT _____

MONTH/YEAR: _____

TO BE CHECKED WEEKLY BY THE NIGHT SHIFT CHARGE NURSE

DATE	DATES ON LAB SUPPLIES	SIGNATURE

COMMENTS: _____

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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 02/09/2011. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards. This deficiency affected three (3) of six (6) smoke compartments, approximately fifty (50) residents, second floor staff and visitors. The facility has the capacity for one-hundred and twelve (112) beds; the census on the day of the survey was one-hundred (100). The findings include: Observation on 02/09/11 at 11:30am revealed that the door leading to the second floor roof area, located on the South side of the facility, could be confused as an exit, as the door was not	K 022	1. A temporary "This Is Not an Exit" sign was placed on the door during the survey. 2. Any resident who is ambulatory or wheelchair ambulatory had the potential to be affected by this practice. 3. A red sign as described in NFPA 101 7.10.8.1* No Exit was placed on the door on the second floor that leads out to the roof. 4. The entire building will be monitored monthly to identify any door that is not but could be considered an exit. If any are identified a permanent sign as described by regulation will be ordered and placed on the door and this information will be submitted to the QA&A Committee for their review and recommendations.	3/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 3/11/11

A deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that her 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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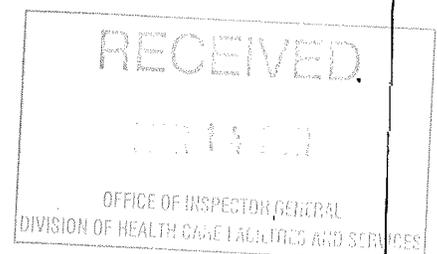
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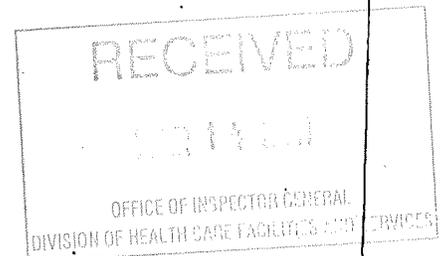
K 022	<p>Continued From page 1 marked as "not an exit". The Maintenance Staff was present during the observation.</p> <p>On 02/09/11 at 11:30am, during an interview with the Maintenance Director, it was revealed that he was unaware of the door not being marked according to NFPA standards. A temporary sign was to be installed until a permanent, compliant sign is to be installed.</p> <p>Reference: NFPA 101 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs. Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards.</p>	K 022		
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass</p>	K 025		3/24/11



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K 025	<p>Continued From page 2</p> <p>panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility has the capacity for one-hundred and twelve (112) beds and the census was one hundred (100) on the day of the survey. The deficiency has the potential to affect all six (6) smoke compartments, one-hundred (100) residents, staff and visitors.</p> <p>The findings include:</p> <p>A tour of the facility conducted on 02/09/11 at 2:00pm, revealed the smoke partition extending above the ceiling, located near the exit to Wesson Court, was noted to be penetrated by newly installed data lines. The space around the data lines was not filled with a material rated equal to the rated partition and resists the passage of smoke.</p> <p>An interview with the Maintenance Director 02/09/11 at 2:00pm revealed he was not aware of the penetrations. The Maintenance staff was instructed to immediately fill the penetrations with the required sealant.</p>	K 025	<ol style="list-style-type: none"> 1. No residents were affected as a result of this practice. 2. All residents had the potential to be affected by this practice. 3. The openings in the smoke partition were repaired during the survey. 4. The IT technician who performed the work that created the penetrations and conducts all IT work for Westminster Terrace was advised of the severity of the issue and to advise the Environmental Services Director in advance if it is necessary for him to do this again. The openings will be repaired immediately upon completion of his work. 	3/24/11



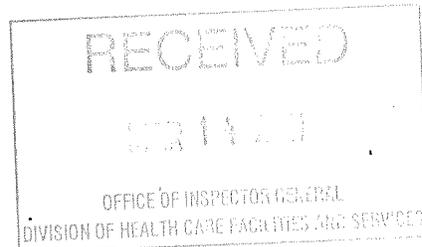
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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K 025	Continued From page 3	K 025		
K 070 SS=D	<p>Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings In Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. This deficiency has the potential to affect all staff located in the basement area offices and staff breakroom.</p> <p>The findings include:</p>	K 070	<ol style="list-style-type: none"> 1. The portable space heater was removed from the office during the survey. No residents were affected by the practice. 2. This deficiency has the potential to affect all staff located in the basement area offices and the staff breakroom. 3. The temperature of the heating element of the space heater was measured and found to be 195°F. Approval was noted on the heater 	2/24/11



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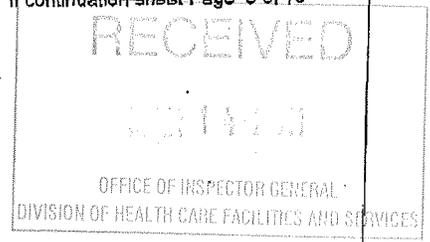
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K 070	<p>Continued From page 4</p> <p>Observation on 02/09/11 at 12:00pm revealed that an unapproved space heater was being used in the Activities Office located in the basement. Unapproved heaters cannot be used in health care facilities due to increased risk of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 02/09/11 at 12:00pm, with the Maintenance Director, revealed the office had no other source for heating and could not produce any documentation that the heater was approved for use in health care facilities. The heater was immediately removed from the office.</p>	K 070	<p>which was returned to the office.</p> <p>An "On the Spot" Inservice will be conducted for ALL staff advising them of the dangers of portable space heaters and the rules governing their use. Anyone who chooses to use such a heater must receive approval from the Environmental Services Director and approval will be noted on the heater after testing.</p> <p>4. Offices will be audited for presence of space heaters weekly on Wednesday by the Environmental Service Director or his designee. If any are found that haven't been approved, they will be removed, tested and approved before being returned to the office.</p>	
K 072 SS=F	<p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.</p> <p>Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas, where the heating elements of such devices do not exceed 212°F (100°C).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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.</p> <p>7.1.10</p>	K 072	<p>1. All items were removed from the corridors on both the first and second floors.</p> <p>2. All residents in the facility had the potential to be affected by this practice.</p>	3/24/11



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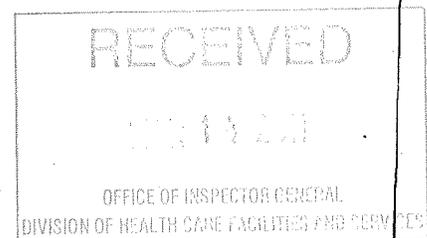
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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K 072	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect one-hundred (100) residents, staff and visitors. The facility has the capacity for one-hundred and twelve (112) beds; the census on the day of the survey was one-hundred (100).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code Survey on 02/09/11 between 10:20am and 4:00pm, with the Maintenance Director, revealed various items located within the resident area corridors. Located in the first floor, North side corridor were a copier, shredder, recycle bin and trash receptacle outside of room 145; a med cart outside of room 151; a patient lift outside of room 146; a wheelchair outside of room 152; and a wheelchair and scale outside of room 158. Located in the first floor, South side were two (2) wheelchairs and a walker outside of room 131; two (2) stools for wall mounted monitors outside of room 137; two soiled linen containers outside of room 138; a wheelchair outside of room 139; and a med cart outside of room 144. Located on the second floor, North side, were a med cart outside of room 245; a patient lift and wheelchair outside of room 252; and a copier and shredder outside of room 258. Located in the second floor, South side were a scale outside of room 231; two (2) stools for wall mounted monitors outside of room 237; and a fish tank outside of room 244. The observations were confirmed with the Maintenance Director, who stated that the items</p>	K 072	<p>3. A procedure has been written and inserviced to all staff stating that no items will be left in the corridors for more than 30 minutes. The inservice also addressed the potential dangers of items left in the corridors that might obstruct passage in the event of a fire or emergency and the responsibility of each staff person to remove items from the corridor or report the issue to the Unit Manager or Charge Nurse.</p> <p>4. A weekly audit will be conducted on Wednesday by the Environmental Service Director or his designee to observe for free passage in the corridors. Findings will be submitted monthly to the QA&A Committee for review and recommendations.</p>	
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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K 072	<p>Continued From page 6</p> <p>in use within the corridors were reviewed and acceptable with the State Fire Marshall.</p> <p>Interview with the Administrator, the Executive Director and the Maintenance Director, during the exiting conference at 4:00pm confirmed the items located in the corridors. The Administrator stated that the paper shredders were there for concerns with HIPPA requirements.</p> <p>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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable 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, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all one-hundred (100) residents, staff and visitors. The facility is licensed for one-hundred and twelve (112) beds and the census on the day of the survey was one-hundred (100).</p> <p>The findings include:</p>	K 072		
K 073 SS=F		K 073	<ol style="list-style-type: none"> 1. All six of the door decorations were removed during the survey, sprayed with chemical retardant, dried for 48 hours tagged with an approval sticker from maintenance and replaced on the doors. 2. This deficiency had the potential to affect all 100 residents. 3. A letter will be sent to family members, responsible parties advising them of the dangers of using items in the 	3/24/11

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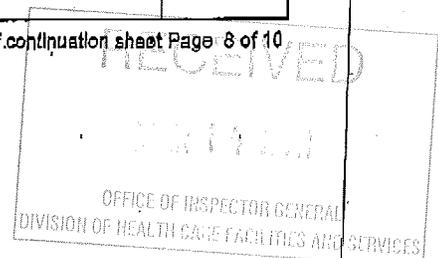
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY 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
K 073	Continued From page 7 Observation on 02/09/11 during the tour of the facility with the Maintenance Director, revealed six resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 145, 148, 151, 156, 250 and 259. Interview with the Maintenance Director on 02/09/11 at 11:00am, revealed they were unaware of the requirement that the decorations had to be flame retardant. The door decorations were immediately removed by the Maintenance staff and treated with a fire retardant coating. He stated that the facility would implement a written policy for documentation.	K 073	facility that are not flame retardant and that all decorations must be given to the maintenance staff when they bring them to the facility so they can be treated. This same information will be placed in admission packets moving forward. An "On the Spot" inservice will be provided to all staff that will include the above information. 4. A monthly door audit is currently being done and this will be added to the audit. These findings will be submitted to the QA&A Committee for their review and recommendations.	
K 076 SS=E	Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	1. Oxygen provider company contacted to relocate oxygen cylinders to the room designated for same. Combustible products were removed from the crash cart room. An appropriate sign was ordered for the Crash Cart room.	3/24/11



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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2011
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K 076	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. This deficiency has the potential to affect four (4) of six (6) smoke compartments and approximately fifty (50) residents, staff and visitors. The facility has the capacity for one-hundred and twelve beds; the census on the day of the survey was one-hundred (100).</p> <p>The findings include:</p> <p>Observation on 02/09/11 at 11:07am, with the Maintenance Director, revealed oxygen cylinder tanks stored in the crash cart storage room outside of resident room 142 on the first floor. The oxygen tanks were stored with the crash cart and within five (5) feet of combustible supplies. This observation was confirmed with the Maintenance Director who stated the cylinders should have been stored in the designated, oxygen storage room located elsewhere on the first floor.</p> <p>Interview with the Maintenance Director on 02/09/11 at 11:07am indicated the tanks would be removed and relocated in the designated oxygen storage room.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (A) Storage locations shall be outdoors in an</p>	K 076	<p>2. Residents (50), based on their location in terms of smoke compartments, had the potential of being affected by this practice.</p> <p>3. Nursing, maintenance and housekeeping staff will be notified by way of "On the Spot" inservice that all oxygen must be stored in the oxygen storage rooms indicated by signs. If they see a tank elsewhere they are to advise the unit manager or charge nurse. Combustible (includes paper) items must not be stored in the same room with oxygen. New signs that are in compliance with NFPA 99 8-3.1.11.2 have been placed on the oxygen storage rooms as well as a sign has been placed on the crash cart room door. Combustible items (paper) stored in the crash cart room have been removed.</p> <p>4. All staff are responsible to monitor proper location of unused oxygen tanks.</p>	

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

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K 076	<p>Continued From page 9</p> <p>enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</p>	K 076	<p>A weekly audit will be conducted by maintenance staff to assure that all oxygen is properly stored. This will be submitted to the QA&A Committee for review and recommendations.</p>	

