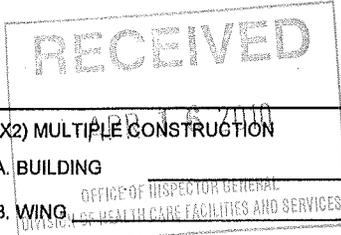


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185137</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  <b>03/26/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard Health survey was conducted on 03/23/10 through 03/26/10 and a Life Safety Code survey was conducted on 03/25/10. Deficiencies were cited with the highest scope/severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	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.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to complete the MDS (minimum data set) assessments at least every three (3) months, not to exceed 92 days, for four (4) of twenty-three (23) sampled residents (#6, #8, #13 and #20 ).  The findings include:  Resident #6 had a quarterly MDS assessment completed on 11/16/09 and the next quarterly assessment was not completed until 02/18/10, 94 days after the last MDS assessment was completed.  Resident #8 had an annual MDS assessment completed on 12/14/09 and the quarterly assessment was not completed until 03/25/10, 101 days after the last MDS assessment was completed.	F 276		

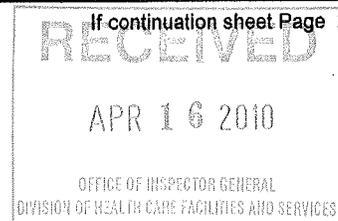
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*NHA* *04/15/10*

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.

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

PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

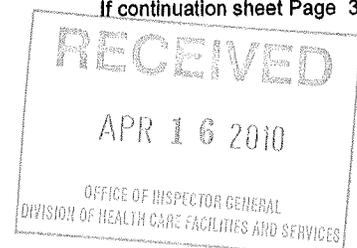
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185137</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER TERRACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218</b>	
(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)	(X6) COMPLETION DATE
F 276	Continued From page 1  Resident #13 had an initial MDS assessment completed on 11/01/09 and the quarterly MDS assessment was not completed until 02/04/10, 94 days after the last MDS assessment was completed.  Resident #20 had an initial MDS assessment completed on 10/01/09 and the quarterly MDS assessment was not completed until 02/04/10, 109 days after the last MDS assessment was completed.  Interview with the MDS Coordinator on 03/25/10 at 9:20am revealed acknowledgement that the quarterly MDS assessment on Resident #8 was late by approximately six (6) days. She stated the facility had downsized staff the prior week which included the other MDS nurse. In addition, she stated that Resident #8 had no significant changes and therefore, the MDS assessment being late would not be an issue.  Interview with the MDS Coordinator on 03/26/10 at 10:10am revealed acknowledgement there were MDS assessments that were completed after the 92 day requirement and she was aware the MDS assessments were behind. The MDS Coordinator stated she was putting in overtime to complete the assessments; however, she did not make administration aware of the situation. After the elimination of the second MDS nurse, the Director of Nursing (DON), the Staff Development Coordinator and the MDS Coordinator were working on a new strategy to assure the assessments were done timely.  Interview with the Director of Nursing (DON) on 03/26/10 at 10:35am revealed the other MDS	F 276	F276  1- The facility's Interdisciplinary Team will review each of the affected resident's record to ensure the current MDS is correct and appropriate for the current care being provided.  2- The Interdisciplinary Team will review the MDS calendar for the past 3 months to ensure all current MDS's are appropriate and accurate for residents currently residing in the facility.  3- The MDS Coordinator will schedule all MDS's in conjunction with the current guidelines. A copy of the Assessment Calendar will be given to the Interdisciplinary Team for review. The Assessment Calendar will also be discussed in the	



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

PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

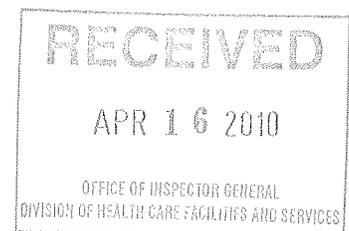
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/26/2010
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 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 276	Continued From page 2 nurse position had been eliminated the week prior and with a census of 95 residents, one MDS nurse could do the assessments as required. She stated there were two staff members in the facility that had experience with the MDS process and could help the MDS Coordinator if the assessments were not being completed within the required time frame. She also stated there are three (3) sister facilities that could assist the MDS Coordinator with the completion of the assessments. The DON stated she had revised the MDS Coordinator's job description and she would only be responsible for the MDS, Resident Assessment Protocols and the care plans.	F 276	AM Clinical meeting to ensure compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	4- The MDS Coordinator will produce a copy of future scheduled assessments for the facility's Quality Assessment and Assurance Team on a monthly basis for three months, and quarterly thereafter, to ensure that solutions are sustained and to determine if further action is needed.  5- The completion date will be May 10, 2010	05/10/10



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

PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

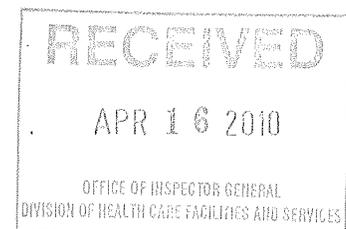
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/26/2010
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 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 441	<p>Continued From page 3</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for three (3) of (23) sampled residents (Residents #21, #22 and #23). The glucometer was not cleaned after performing the fingerstick glucose level between Resident #21, Resident #22 and Resident #23.</p> <p>The findings include:</p> <p>Observation on 03/25/10 at 11:10am revealed Licensed Practical Nurse (LPN) #1 performed a fingerstick glucose level on Resident #21, admitted with a diagnosis of Insulin Dependent Diabetes, the LPN returned to the medication cart and then preceded to the room of Resident #22. The glucometer had not been cleaned, but the LPN did a fingerstick glucose level on Resident #22, admitted with a diagnosis of Non-Insulin Dependent Diabetes, and then with the</p>	F 441	<p>F441</p> <ol style="list-style-type: none"> <li>1- All glucometers have been cleaned.</li> <li>2- All glucometers will be cleaned between all residents per the manufacturer's guidelines.</li> <li>3- All nursing staff will be inserviced on glucometer cleanliness by Director of Nursing or designee. Director of Nursing or designee will audit nursing staff on a daily basis to ensure glucometer cleanliness and infection control guidelines are being met.</li> <li>4- The daily audits will be presented to the facility's Quality Assessment and Assurance Team monthly X 3 months, and quarterly thereafter, in order to ensure solutions are sustained and to</li> </ol>	



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

PRINTED: 04/06/2010  
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  03/26/2010
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 441	<p>Continued From page 4</p> <p>glucometer still cleaned the LPN immediately used it on Resident #23, admitted with a diagnosis of Insulin Dependent Diabetes.</p> <p>Interview with LPN #1 on 03/25/10 at 11:30am revealed the glucometer was not cleaned between residents because the strips stand up on the glucometer and no blood would get on the machine. She also stated the glucometer was for use on multiple residents.</p> <p>Interview with the Director of Nursing (DON) on 03/25/10 at 1:40pm revealed wipes were ordered two weeks prior to clean the glucometer. The DON expected the glucometer to be cleaned between residents. She stated the wipes were placed on the nursing units on 03/25/10 and the staff had been in-serviced. The DON was unsure how the staff cleaned the glucometer prior to obtaining the cleaning wipes. She acknowledged not cleaning the glucometer between residents could be an infection control issue.</p> <p>Interview with the DON on 03/26/10 at 10:40am revealed the cleaning wipes contain bleach solution and could not be used on the glucometer according to the manufacture's guidelines. The manufacturer's guidelines state the glucometer should be cleaned with a damp cloth and a mild soap/detergent. The DON stated she had never seen blood on the glucometers but could not assure the glucometers were not contaminated.</p> <p>The facility policy on obtaining a fingerstick glucose level reviewed in 08/2009, states use clean reusable equipment according to the manufacturer instructions.</p>	F 441	<p>determine if further measures are needed.</p> <p>5- The completion date will be May 10, 2010.</p>	05/10/10	



RECEIVED

APR 16 2010

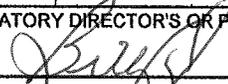
PRINTED: 04/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185137</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/25/2010</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESTMINSTER TERRACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218</b>
--	---

(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	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was initiated and concluded on 03/25/10 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at a Scope/Severity of "E".</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure all portable fire extinguishers were accessible for staff use. One (1) fire extinguisher was located behind a stereo/cabinet in the facility conference room.</p> <p>The findings include:</p> <p>Observation on 3/25/10 at 9:00am revealed a fire extinguisher in the conference room was blocked by a stereo and cabinet.</p> <p>Interview with the Maintenance director on 3/25/10 revealed the extinguisher should be accessible for use.</p>	K 000	<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> <p>OK064</p> <ol style="list-style-type: none"> <li>The stereo and cabinet have been removed to ensure that the fire extinguisher is accessible.</li> <li>All fire extinguishers locations within the facility have been evaluated; and all are accessible for staff use.</li> <li>All staff will be inserviced by the Director of Environmental Services or designee regarding the accessibility of fire extinguishers.</li> <li>A fire extinguisher audit will be conducted by the Safety Team on a monthly basis. The findings will be presented to the facility's Quality Assessment and Assurance Team on a monthly basis X3, then quarterly thereafter, to ensure solutions are sustained and to determine if further action is needed.</li> <li>The completion date will be May 10, 2010</li> </ol>	05/10/10
K 064 SS=E		K 064		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>NHA</b>	(X6) DATE <b>04/15/10</b>
--	---------------------	------------------------------

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.