

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

PRINTED: 07/10/2013
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 06/27/2013
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 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>A standard recertification survey was initiated on 06/25/13 and concluded on 06/27/13 with deficiencies cited at the highest scope and severity of an "F". A Life Safety Code survey was initiated and concluded on 06/26/13 with deficiencies cited at the highest scope and severity of an "E" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to ensure the dignity of two (2) of eighteen (18) sampled and five (5) unsampled residents (Residents #3 and #11). Resident #3 was not allowed to go outside without staff supervision (physician's order to allow the resident to go out unsupervised) and Resident #11 went to a doctor's appointment without a bath.</p> <p>The findings include:</p> <p>The facility did not have a policy for dignity.</p> <p>Observation of Resident #11, on 06/26/13 at 11:21 AM, revealed the resident up in a</p>	F 241	<p>This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>F241</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility does have a policy on dignity which was in place at the time of the incident. Nursing management (DON and ADON's) were provided education on this policy on 7/10/13 by the Administrator. Regarding concerns voiced by resident #11, nursing staff were educated by the ADON on 6/28/13 regarding the importance of maintaining resident dignity, am care, coordination of care, and managing appointments. Regarding resident #3, Occupational therapy performed a safety assessment on resident #3 on 7/12/13. As a result of the assessment resident #3 is now allowed to go out of doors without supervision. Resident #3 has been informed of this change.</p>	8/2/13

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

TITLE

(X6) DATE

X 

X Executive Director

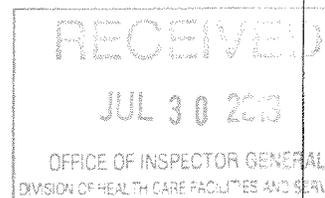
X 7/28/13

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

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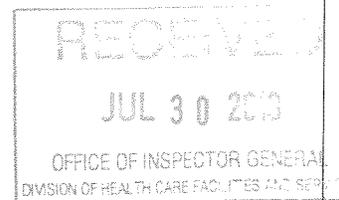
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F 241	<p>Continued From page 1 wheelchair in his/her room.</p> <p>Interview with Resident #11 on 06/26/13 at 11:21 AM revealed the resident upset at the nursing staff over the treatment received earlier in the day. The resident stated the facility did not remind him/her of a doctor's appointment that morning until breakfast was served. The resident stated the facility then told him/her that the resident had fifteen minutes to eat. The resident stated he/she was upset. The resident stated he/she was taken to the appointment without having had a bath or a clothing change.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 06/26/13 at 2:20 PM, revealed she did not realize the resident had a doctor's appointment and did not provide the resident with assistance to bathe and change clothing. She stated residents received a bath/shower twice a week; however, she should have assisted the resident to clean up that morning before breakfast.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 06/26/13 at 4:02 PM, revealed he had Informed Resident #11 of the doctor's appointment for 6/26/13 on 06/25/13. He stated the facility had to wait fifteen (15) minutes for the resident to eat. He stated residents received baths twice a week; however, the resident should have been assisted to clean up.</p> <p>Interview with the Assistant Director of Nursing #1 (ADON), on 06/27/13 at 2:47 PM, revealed residents received morning care; however, she was not sure if Resident #11 had received a partial bath or had a change in clothing prior to his/her doctor's appointment. She stated the</p>	F 241	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice. On 7/15/13, the director of social services performed a survey of interviewable residents who'd had an MD appt in the last month to determine if there were concerns. The director of social services also completed a survey of interviewable residents who are independently mobile to determine if their independence was being respected. On 7/25/13 the director of social services interviewed families and/or responsible parties of noninterviewable residents to determine if they had concerns with facility staff honoring resident dignity and independence. Care plan changes were also reviewed. No other residents were found to have concerns with either aspect of dignity.</p>		



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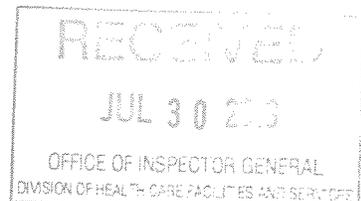
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F 241	<p>Continued From page 2</p> <p>resident should have been taken care of earlier in the morning since a morning doctor's appointment was scheduled. She further stated the resident should not have been sent out without this care.</p> <p>Interview with Resident #3 on 06/26/13 revealed the facility did not allow him/her to go out of doors alone in his/her electric wheelchair and he/she felt like a prisoner in the facility. The resident stated he/she was mobile in the electric wheelchair upon admission to the facility on 01/14/12 and was allowed to go out of doors unsupervised until a fall from the chair on 06/07/13. Resident #3 stated the fall was due to "I did a foolish thing and tried to back the wheelchair up into the gazebo and caused the fall". However, Resident #3 stated he/she was not informed of only going out of doors with staff supervision until after going out alone on 06/15/13. The resident indicated when that occurred he/she was brought back into the facility by staff, made to feel like a child and was just then informed of the need for supervision when going out of doors. Resident #3 further indicated not wanting to go out of doors with staff because he/she was an independent adult. The resident asked the surveyor "Where were the staff when I was at Normandy?" Interview with the resident's daughter (present at the time of the individual interview) revealed she was aware of the physician's order for the resident to go out of the facility unsupervised after 06/15/13 and she discussed this with the Director of Nursing who told her she didn't care what the physician's order said.</p> <p>Interview with Certified Nursing Assistant (CNA)</p>	F 241	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur.</p> <p>The director of social services will perform in-service training for all employees regarding quality of life and dignity on 7/29/13, 7/30/13, and 8/1/13. The interdisciplinary team has implemented a new communication protocol which includes coordination of physician appointments. The program requires the first shift nurse to notify any residents of appointments scheduled for the next day. The second shift nurse will verify that the resident has been notified and coordinate changes to care with input from the resident. The day shift nurse the day of the appointment will remind resident and ensure that pre appointment care is provided in accordance with the resident's needs and desires. The staff nurse scheduling or receiving notification of a physician appointment will notify the assistant director of nursing who will oversee the process and be aware of all appointments in order to coordinate services. The ADON will provide the DON with a list of appointments weekly in advance. The interdisciplinary team was educated by the administrator on 7/11/13 on resident dignity and coordination of changes which may impose on resident rights. The care planning process was reviewed and a new step added.</p>		



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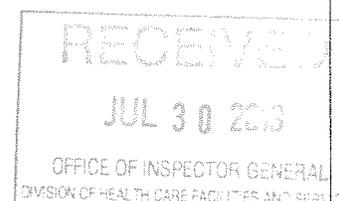
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F 241	<p>Continued From page 3</p> <p>#6 on 06/27/13 at 9:50 AM revealed she had worked at the facility for six (6) months and was familiar with Resident #3 going out of doors unsupervised during that time. CNA #6 stated she had been informed the resident could no longer go out of doors alone by the DON. She further stated she thought it was the resident's right to be treated with dignity and to go out of the facility alone if he/she had been trained in electric wheelchair safety.</p> <p>Interview with RN #5 on 06/27/13 at 10:20 AM revealed he knew Resident #3 very well and was familiar with the resident going out of doors alone in the electric wheelchair. RN #5 stated he knew Resident #3 enjoyed sitting in the sun and people watching and felt it was good for the resident as the resident was depressed. RN #5 further stated it was Resident #3's right to be treated as an adult with dignity and to be allowed to continue going out of doors alone if properly educated in wheelchair safety.</p> <p>Interview with the Assistant Director of Nursing (ADON) #2 on 06/27/13 at 10:50 AM revealed she was aware Resident #3 had gone out of doors independently since admission to the facility and was aware of the order, dated 06/17/13, for the resident to be unsupervised when going out of doors. She stated she thought it was explained adequately to Resident #3 why he/she should go out of doors with staff (decision made with verbal order on 06/13/13) and she was sorry he/she felt he/she had been treated in an undignified manner on 06/15/13 when he/she was out of doors unsupervised. ADON #3 indicated the DON made a sign posted at the nursing station (dated 06/21/13) which stated Resident #3</p>	F 241	<p>If any change in a residents care presents a potential alteration in independence, right to choose, or other resident right a documented assessment will be presented to the administrator for review and approval. The same information will then be presented to the resident and a detailed explanation provided why the facility has made the decision. This meeting will be documented by social services.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>All approvals issued by the Administrator will be reviewed by the QA committee monthly. This will be a permanent, ongoing review process with no end date to ensure all resident rights are enforced. Modifications to the plan of correction and further actions will be based upon committee recommendation.</p>		



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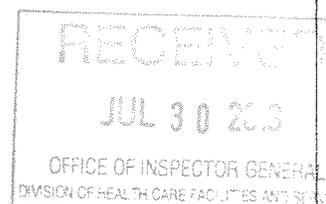
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F 241	Continued From page 4 was to go out of doors only with staff supervision and that was after the order of 06/17/13 which stated the resident could go out of doors unsupervised. She further stated all residents had the right to be treated with respect and with dignity.	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure three (3) of eighteen (18) sampled and five (5) unsampled residents were notified of their therapy times in advance. Residents #10, #11 and #12 expressed concern over therapists taking them to therapy without regard for what they were doing at the time. The findings include: The facility had no policy for informing residents of their therapy schedules in advance. Observation of Resident #10, on 06/25/13 at	F 242	F242 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Director of Rehab Services provided residents #10, #11, and #12 with therapy schedules based upon the resident's preferences on 6/28/13. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Social Services interviewed all residents currently receiving therapy on 7/12/13. No other residents expressed concern regarding scheduling therapy.	7/28/13	



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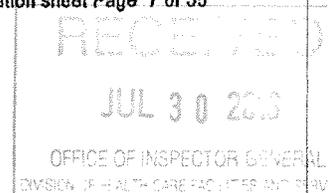
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F 242	<p>Continued From page 5</p> <p>11:10 AM, revealed two (2) therapy staff entered Resident #10's room and said let's go. The resident made a remark as to who died and made them the boss; however, the resident left with the staff.</p> <p>Review of the clinical record for Resident #10, revealed the facility admitted the resident with diagnoses of Chronic Pain Syndrome and Diabetes. The facility completed an admission Minimum Data Set (MDS) assessment of the resident on 06/19/13 which revealed the resident was cognitively intact and required assistance with care needs.</p> <p>Interview with Resident #10, on 06/27/13 at 9:30 AM, revealed therapy never gave the resident any idea when therapy would take place. The resident stated this was a concern as the resident might be in pain or need to use the restroom and was not always prepared to go to therapy right then. The resident stated one morning, while eating breakfast, therapy came to take him/her to therapy and sat and waited for the resident to finish breakfast, making the resident feel uncomfortable and rushed.</p> <p>Interview with Resident #11, on 06/26/13 at 11:10 AM, revealed therapy just came at haphazard times saying let's go and you had to go with them right then. The resident stated this could be upsetting, but he/she did not pass along the information to the therapist in order to be a good patient and not cause problems.</p> <p>Interview with Resident #12, on 06/27/13 at 1:10 PM, revealed therapy showed up and interrupted visits with family and friends. He/she stated</p>	F 242	<p>What measures will be put into place /systemic changes made to ensure that all deficient practice will not recur. The facility policy on Quality of Life -- Self Determination and Participation was reviewed and modified on 7/5/13 to include details on scheduling therapy. All therapy staff was in serviced on 6/28/13 by the Director of Rehab Services on resident rights. At the time of the initial therapy evaluation, all residents will be asked therapy schedule preferences and a schedule will be developed weekly with adjustments for off-campus appointments. A copy of the agreed upon weekly schedule will be provided to each resident, posted in the residents room and posted at the nurses' station.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained. The Director of Rehab Services will randomly interview 3 therapy residents each week to ensure the schedule meets their needs and is being communicated. The QA committee will review results monthly and provide recommendation. Once 100% compliance has been achieved for four (4) consecutive weeks, the audits will be reduced to monthly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.</p>		



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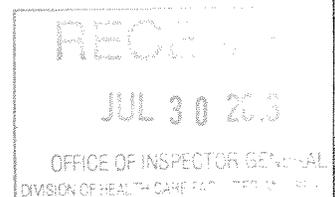
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F 242	Continued From page 6 visitors were a very important part of his/her day. Interview with the Occupational Therapist on the rehabilitation unit, on 06/27/13 at 2:00 PM, revealed it would be difficult to give advance notice to residents regarding therapy appointments; however, it would be discussed. He stated there were currently eight (8) residents on the rehab unit. Interview with the Assistant Director of Nursing #1, on 06/27/13 at 2:47 PM, revealed she was not aware of the resident concerns regarding therapy. She stated she would talk with the residents and therapy.	F 242			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy, it was determined the facility failed to provide on-going programs of activities to meet the assessed interests and needs for six (6) of eighteen (18) sampled and five (5) unsampled residents (Residents #2, #6, #10, #11, #12 and #15). The facility failed to complete individualized assessments of residents current physical and mental limitations, personal history, personal identity, life style, and cultural background for each resident in order to develop an on-going	F 248	F248 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Activities completed activity assessments and developed activity care plans on residents #2, #6, #10, #11, #12, and #15 by 7/19/13. How the facility will identify other residents having the potential to be affected by the same deficient practice. All resident records have been reviewed by the activity director and 33 other residents were found to be affected. Those residents have had activity assessments completed and care plans updated with activity preferences by 7/19/13.	7/28/13	



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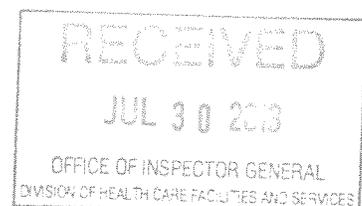
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F 248	<p>Continued From page 7</p> <p>program of activities reflective of the residents interests and needs and abilities to ensure the resident functioned at the highest level.</p> <p>The findings include:</p> <p>Review of the facility policy, Individualized Activities and Room Visit Program, dated 12/2011, revealed activities are reflective of the Individual's activity interests, as identified in the Activity Assessment, progress notes and the comprehensive care plan.</p> <p>Review of the facility policy for Activity Assessments, dated 12/11, revealed an activity assessment must be completed within fourteen (14) days and must reflect the resident's choices and interests.</p> <p>1. Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Cancer of the Esophagus and Cerebral Vascular Accident. The facility completed an admission MDS assessment on the resident on 05/30/13 which indicated the resident was cognitively intact. The resident required extensive assistance with transfers, ambulating and dressing. The resident enjoyed reading the news, music and being outdoors as indicated by the MDS.</p> <p>Review of the clinical record for Resident #6's revealed no Activity Assessment was located.</p> <p>Review of the care plan for Resident #6, revealed there was no activity care plan.</p> <p>Review of the activity attendance records for</p>	F 248	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur.</p> <p>A new admission care planning rounds program has been developed and implemented on 7/23/13. The interdisciplinary team (Director of Nursing, Food Service Director, Director of Social Services, Activity Director, Director of Rehab Services, and MDS Coordinator) will have a walking rounds care plan meeting within 5 days of admission on all residents. Facility policies on Care Planning were reviewed and updated on 7/17/13. At this time activity assessments will be completed and initial care plans developed by the Activity Director within 5 days of admission. Initial care plan will include activity preferences and appropriate staff interventions. Assessments will continue to be reviewed and care plans updated by the Activity Director according to the MDS schedule.</p>		



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F 248	<p>Continued From page 8</p> <p>Resident #6, revealed the resident had visits from activity staff for reading/writing.</p> <p>Interview with Resident #6, on 06/26/13 at 11:00 AM, revealed the resident enjoyed sports, being outdoors, watching baseball games on TV, movies and music concerts. The resident stated a person had come to the room and offered puzzles which were all right; however, the resident was tired of puzzles.</p> <p>2. Review of the clinical record for Resident #10, revealed the facility admitted the resident to the rehab unit with diagnoses of Chronic Pain Syndrome, Dementia and Diabetes. The facility completed an admission Minimum Data Set (MDS) assessment on the resident on 06/19/13 which revealed the resident was cognitively intact and required extensive assistance with transfers, walking and dressing. The resident enjoyed pets, the outdoors, church, music and news.</p> <p>Review of the record for Resident #10 revealed no activity assessment reflecting the resident's personal history and identity, life style, and cultural background was located.</p> <p>Review of the care plan for Resident #10, revealed there were no interventions in place to provide the resident with activities of interest as assessed on the MDS.</p> <p>Review of the activity attendance records for Resident #10, revealed the resident had room visits consisting of offering food and reading/writing.</p> <p>Interview with Resident #10, on 06/27/13 at 10:26</p>	F 248	<p>How the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Medical Records Coordinator will audit 5 new admissions each month to ensure that activity assessments have been completed and activity care plans are developed within 5 days of admission and content is appropriate. Results of the audits will be presented to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.</p>	



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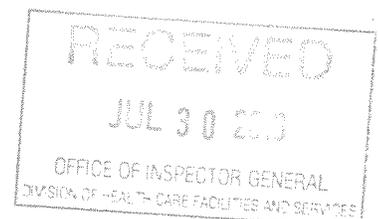
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2013
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F 248	<p>Continued From page 9</p> <p>AM, revealed the resident had activities staff come to the room on occasion to offer food and give puzzles. The resident stated interest included pets, going outdoors, music, and reading the news. The resident stated these activities were not offered.</p> <p>3. Review of the clinical record for Resident #11, revealed the facility admitted the resident with diagnoses of Total Right Hip Replacement and Anxiety. The facility had not yet completed an MDS on the resident admitted on 06/19/13.</p> <p>Review of the record for Resident #11 revealed no activity assessment was completed.</p> <p>Review of the initial care plan for Resident #11 revealed no interventions were in place for activities.</p> <p>Interview with Resident #11, on 06/26/13 at 3:00 PM, revealed someone had visited and wanted to give the resident a puzzle; however, the resident disliked puzzles and declined.</p> <p>Review of the clinical record for Resident #12, revealed the facility admitted the resident with diagnoses of Osteomyelitis, Peripheral Vascular Disease and Amputation of the Great Toe. The facility completed an admission MDS assessment on 05/13/13. The resident required extensive assistance with transfers, walking, dressing, and hygiene. The resident scored a nine (9) of fifteen (15) on the mental assessment. The resident was found to value interaction with groups of people, attend religious events and being outdoors.</p>	F 248			

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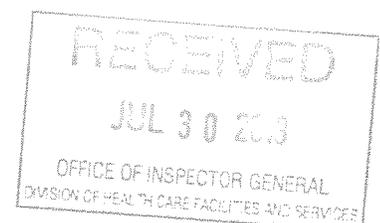
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F 248	<p>Continued From page 10</p> <p>4. Review of the record for Resident #12 revealed no activity assessment reflecting the resident's personal history and identity, life style, and cultural background was located.</p> <p>Review of the care plan for Resident #12, revealed the resident would persue independent activities and the facility would encourage the resident to plan independent activities with the facility making materials available if needed. The care plan did not contain interventions identifying what activilles the resident liked or what materials would be made available.</p> <p>Revlw of the activity attendance record for Resident #12, revealed the resident had visits from activities for reading and writing.</p> <p>Interview with Resident #12, on 06/26/13 at 3:40 PM, revealed people did visit and talk; however, no one offered any activities on or off the rehab unit and no activity materials were left for him/her. The resident stated it would be great to go outside every day, weather permitting.</p> <p>Interview with the Activity Director on 06/27/13 at 4:30 PM, revealed she was not aware of the activity policy to complete an activity assessment on residents. She stated the assessment was the MDS. She revealed the residents' personal histories, life styles, life roles and cultural backgrounds were not assessed for incorporation into an activity care plan. She stated residents on the rehab unit were focused on therapy and therefore, no activilles programs were held on the rehab unit. She stated staff took a cart room to room and offer puzzles, reading materials and crafts. She stated all residents on the rehab unit</p>	F 248			



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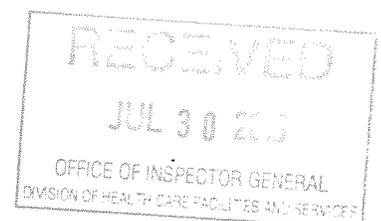
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F 248	<p>Continued From page 11</p> <p>were offered one to one visits. She indicated that looking at the residents' care plans did not reveal what specific interests the residents had or how to ensure these interests were provided within the physical/mental limitations each resident experienced.</p> <p>5. Review of the clinical record revealed the facility admitted Resident #15 on 04/16/13 with diagnoses of Urinary Tract infection, Arthritis and Depression. Review of the Initial Minimum Data Set (MDS) dated 04/23/13 revealed the resident's activities preferences were listening to music and doing activities with a group of people. Continued review of the clinical record revealed there was no Activity Assessment completed. Review of the care plan for Resident #15, revealed no activity care plan.</p> <p>Observation of Resident #15, on 06/27/13 at 10:20 AM, revealed the resident in his/her room with door shut. Continued observation of the resident, at 10:35 AM, revealed no staff entered the room to invite the resident to the BINGO activity. The resident remained in his/her room while the BINGO activity was in progress.</p> <p>Interview with Resident #15, on 06/27/13 at 10:35 AM, revealed the resident enjoyed music, socializing with others, and reading. The resident also stated being aware of the activity calendar posted in his/her room; however, no staff invited the resident to participate in the BINGO activity.</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 06/27/13 at 10:40 AM, revealed he had no clear knowledge of Resident #15's activity goals. CNA #9 further stated he did not invite the</p>	F 248		



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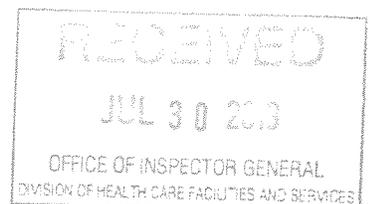
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F 248	<p>Continued From page 12 resident to participate in the BINGO activity.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/27/13 at 10:45 AM, revealed Resident #15 showed no interest in activities; therefore the staff allowed the resident to not participate. She stated the staff had no intervention in place to identify and address the reasons why the resident refused the activity.</p> <p>Interview with the Activity Director, on 06/27/13 at 2:05 PM, revealed Resident #15's activity care plan wasn't developed. She continued to state without an activity care plan staff were unable to coordinate activities to meet the psychosocial needs of the resident.</p> <p>6. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 10/05/10 with diagnoses of Alzheimer's Disease, Senile Dementia and Venous Insufficiency. Review of the Annual Minimum Data Set (MDS) dated 06/04/13 revealed the resident liked to listen to music, go outside when good weather and participate in religious practices. Continued review of the clinical record did not detail what activity the resident participated.</p> <p>Observation of Resident #2, on 06/25/13 at 3:50 PM and on 06/26/13 at 9:30 AM and at 11:00 AM, revealed Resident #2 was sitting in his/her room alone with no music playing in the room.</p> <p>Interview with the Activity Director, on 06/27/13 at 5:00 PM, revealed the facility does not have a system in place to specify what activity actually took place.</p>	F 248			



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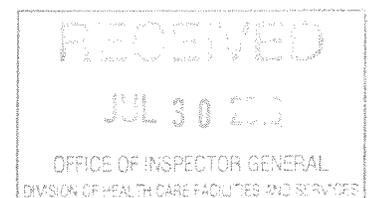
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, recorded review and facility policy review it was determined the facility failed to develop a care plan with measurable goals and interventions to address the care and treatment related to two (2) of eighteen (18) sampled and five (5) unsampled residents (Residents #6 and #15). The facility failed to develop a plan of care for Resident (#15) related to the residents activity choices. The facility failed to revise Resident #6's plan of care for behaviors and history of C-Diff. The findings include:</p>	F 279	<p>F279 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The assistant director of nursing developed a care plan for C-Diff on resident #6 on 6/28/13. The Activity Director completed the activity assessment and developed an activity care plan on resident #15 on 7/19/13.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of all care plans was completed on 7/19/13 by the director of nursing and activity director. 33 other residents were found to be affected. Those care plans were updated based upon the appropriate assessment data.</p>	7/28/13	



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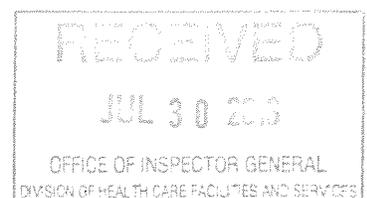
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F 279	<p>Continued From page 14</p> <p>Review of the facility policy for development of Care Plans, dated 12/11, revealed the interdisciplinary team (IDT) was responsible for development of an individualized care plan for each resident with measureable goals and time frames. The IDT identifies the highest level of functioning the resident may be expected to attain and the care plan is revised as information about the resident's condition changes. The IDT is responsible for reviewing and updating the care plan.</p> <p>Review of the clinical record revealed the facility admitted Resident #15 on 04/16/13 with diagnoses Urinary Tract Infection, Arthritis and Depression. Review of the Initial Minimum Data Set (MDS) dated 04/23/13 revealed the resident's activities preferences are listening to music and doing activities with a group of people. Review of comprehensive care plan for Resident #15 revealed no evidence of the facility developed an activity care plan.</p> <p>Observation of Resident #15, on 06/27/13 at 10:20 AM, revealed the resident in the room with the door shut. Continued observation of the resident, at 10:35 AM, revealed no staff entered the room to invite the resident to the BINGO activity. The resident remained in the room while the BINGO activity was in progress.</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 06/27/13 at 10:40 AM, revealed no clear knowledge of Resident #15's activity goals. CNA #9 further stated he did not invite the resident to participate in the BINGO activity.</p>	F 279	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur.</p> <p>Activity assessments will be completed and initial care plans developed by the Activity Director within 5 days of admission via the newly developed admission care plan rounds program. Initial care plan will include activity preferences and appropriate staff interventions.</p> <p>Upon receipt of a physician order or lab results, the nurse will develop a new temporary care plan or update the care plan with appropriate interventions. Copies of new orders and lab results will be reviewed within 24 hours by the Assistant Director of Nursing or Weekend RN Supervisor to ensure that care plans have been initiated or updated. Copies of new orders will be provided to the Director of Nursing for review and validation of appropriate action completed. Facility policy on Care Plans reviewed and updated on 7/17/13 to reflect this change.</p>		



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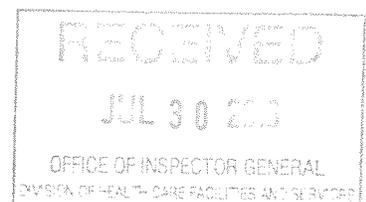
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F 279	Continued From page 15 Interview with Licensed Practical Nurse (LPN) #1, on 06/27/13 at 10:45 AM, revealed Resident #15 showed no interest in the activity; therefore, the staff allowed the resident to not participate. She stated the staff had no intervention in place to identify and address the reasons why the resident refused activities. Interview with Activity Director, on 06/27/13 at 2:05 PM, revealed Resident #15's activity care plan wasn't developed. She continued to state without an activity care plan staff were unable to coordinate activities to meet the psychosocial needs of the resident. Observation of Resident #6, on 06/26/13 at 8:20 AM, revealed an isolation cart in the hallway outside the resident's room. Interview with Licensed Practical Nurse (LPN) #5, on 06/26/13 at 8:25 AM, revealed the resident had a positive stool culture for Clostridium Difficile Colitis and required contact precautions (isolation). Observation of Resident #6, on 06/25/13 at 12:05 PM, revealed the resident sitting in the therapy room attempting to eat a meal. The resident was noted to eat several small bites and become nauseated. Review of the clinical record for Resident #6, revealed the facility admitted the resident from the hospital with diagnoses of recent Clostridium Difficile Colitis, Depression and Cerebral Vascular Accident. The facility completed an admission	F 279	How the facility plans to monitor its performance to ensure that solutions are sustained. Medical Records will audit 10% of care plans monthly to ensure that all care plans are up to date with new orders, lab results, and other interventions. Results of the audit will be provided to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.	



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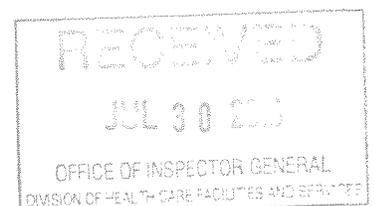
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F 279	<p>Continued From page 16</p> <p>Minimum Data Set (MD'S) assessment on the resident on 05/30/13 which revealed the resident required extensive assistance with transfers, dressing, bathing and ambulation. The resident was cognitively intact. The resident was continent of stool.</p> <p>Review of the nursing notes for Resident #6 revealed the resident was noted to have episodes of Incontinent of bowel and bladder on 06/12/13 at 4:47 AM, on 06/13/13 at 5:36 PM, on 06/17/13 at 11:30 AM, on 06/18/13 at 10:15 AM, on 6/19/13 at 3:52 AM, on 06/23/13 at 12:14 PM and on 06/25/13 at 1:27 PM.</p> <p>Review of the care plan for Resident #6 revealed no evidence of the facility developing a care plan addressing the resident's history of Clostridium Difficile Colitis or Interventions to prevent the spread of Infection should the resident relapse.</p> <p>Review of the laboratory results for Resident #6, revealed a stool culture obtained by the facility on 06/25/13 was positive for Clostridium Difficile Colitis.</p> <p>Interview with LPN #5, on 06/26/13 at 8:20 AM, revealed the resident did have a history of Clostridium Difficile Colitis in the hospital and the facility was aware of this. He stated there was no care plan located for this concern; however, there should have been one to address prevention of the spread of infection. He stated the resident should not have eaten in the therapy room on 06/25/13 when having diarrhea.</p> <p>Interview with the Assistant Director of Nursing, on 06/27/13 at 2:47 PM, revealed a care plan</p>	F 279			



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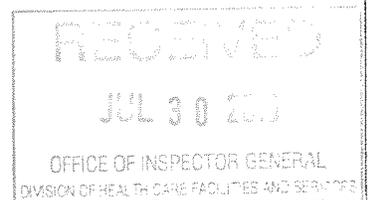
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F 279	Continued From page 17	F 279		
F 280 SS=D	<p>should have been developed addressing the resident's recent history of Clostridium Difficile Collitis to prevent the spread of infection.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING 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, record review and policy review, it was determined the facility failed to revise one (1) of eighteen (18) sampled and five (5) unsampled resident care plans (Resident #6) to reflect the resident being placed in isolation. Resident #6 developed Clostridium</p>	F 280	<p>F280 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plan for resident #6 was updated by the assistant director of nursing on 6/28/13 to include details of treatment for Clostridium Difficile Colitis and being placed in isolation.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of all care plans was completed by the director of nursing on 7/19/13. No other residents were found to be affected by this deficient practice.</p>	7/28/13



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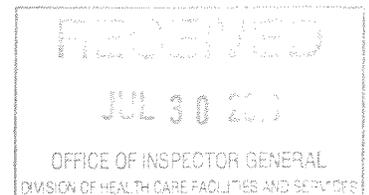
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
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F 280	<p>Continued From page 18 Difficile Colitis and required isolation.</p> <p>The findings include:</p> <p>Review of the facility policy for Care Plans, dated 12/11, revealed the Interdisciplinary Team (IDT) was responsible for developing an individual care plan for each resident with measurable goals and time frames. The IDT identifies the highest level of functioning a resident may be expected to attain. The care plan was reviewed and revised as information about the resident's condition changed.</p> <p>Review of the clinical record for Resident #6, revealed the facility admitted the resident with diagnoses of Cancer of the Esophagus and Cerebral Vascular Accident. The facility completed an admission Minimum Data Set (MDS) assessment for Resident #6 on 05/30/13 which revealed the resident required extensive assistance with all care.</p> <p>Review of the comprehensive care plan for Resident #6, revealed no evidence of documentation regarding the resident developing Clostridium Difficile Colitis and being placed in isolation on 06/25/13 when laboratory results were called to the facility.</p> <p>Interview with Registered Nurse #3, on 06/27/13 at 2:00 PM, revealed the IDT updated resident care plans as needed.</p> <p>Interview with MDS Coordinator #1, on 06/27/13 2:09 PM, revealed care plans are revised quarterly and when changes occurred. She stated information regarding residents and any</p>	F 280	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. Upon receipt of a physician order or lab results, the nurse will develop a new temporary care plan or update the care plan with appropriate interventions. Copies of new orders and lab results will be reviewed within 24 hours by the Assistant Director of Nursing or Weekend RN Supervisor to ensure that care plans have been initiated or updated. Copies of new orders will be provided to the Director of Nursing for review and validation of appropriate action completed. Facility policies on Care Plans have been reviewed and updated on 7/17/13 to reflect this change.</p>	



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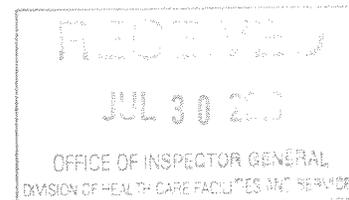
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F 280	Continued From page 19 changes were obtained on a dally basis during morning meetings with other clinical staff. She stated she was aware Resident #6 had been placed in isolation; however, she had no reason for the care plan not being updated to reflect the resident's isolation. Interview with the Assistant Director of Nursing #1, on 06/27/13 at 2:47 PM, revealed care plans were to be revised as residents' condillions warranted to accurately reflect the resident's needs.	F 280	<p>How the facility plans to monitor its performance to ensure that solutions are sustained. Medical Records will audit 10% of care plans monthly to ensure that all care plans are up to date with new orders, lab results, and other interventions. Results of the audit will be provided to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.</p> <p>F309 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The nurse practitioner order for Resident #3 was transcribed by the assistant director of nursing on 6/28/13 to ensure the order was followed. A safety assessment was performed on resident #3 by a staff occupational therapist on 6/28/13. The resident was found to be safe operating the electric wheelchair unsupervised.</p>	7/28/13	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must recelve 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 record review, interview and polcy review it was determined the facility failed to follow the most current physician order and failed to identify a safety risk for one (1) of eighteen (18) sampled and four (4) unsampled residents (Resident #3). A physician/nurse practitioner's order to allow Resident #3 to go out of doors in his/her electric wheelchair unsupervised dated 06/17/13 was not transcribed by nursing to	F 309			



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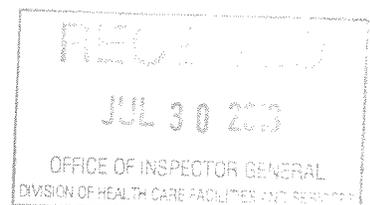
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F 309	<p>Continued From page 20</p> <p>ensure the order was followed. In addition, the safety risk for Resident #3 in an electric wheelchair out of doors unsupervised was not identified.</p> <p>The findings include:</p> <p>No facility policy regarding transcription of physician orders was provided. Review of the policy Safety and Supervision of Residents dated December 2011 revealed #2. Safety risks and environmental hazards are identified on an ongoing basis.</p> <p>Review of Resident #3's clinical record revealed the facility admitted the resident on 01/14/12 with diagnoses to include Diabetes, Peripheral Vascular Disease and Depression. Review of the initial nursing assessment dated 01/14/12 revealed Resident #3 used an electric wheelchair for mobility and further record review indicated the resident continued to do so independently until a fall from the wheelchair out of doors on 06/07/13. A review of the comprehensive nursing care plan for Resident #3 indicated a strength was the resident enjoyed going outside (unsupervised). . . dated 03/27/13. Review of the Minimum Data Set (MDS) (an assessment document for residents of long term care facilities) revealed the facility scored the resident as a fourteen (14) in cognition (Intact cognition) on 01/03/13. Further review of the MDS revealed Resident #3 was self sufficient in the electric wheelchair.</p> <p>Interview with Resident #3, on 06/26/13 at 2:00 PM, revealed he/she had gone out of doors unsupervised since admission to the facility in</p>	F 309	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice. A chart audit was completed by medical records on 7/19/13 and no other residents were found to be affected by this deficient practice. An assessment of all residents using electric wheelchairs and/or electric scooters was completed by a staff occupational therapist on 7/19/13. No new safety concerns were identified.</p>		



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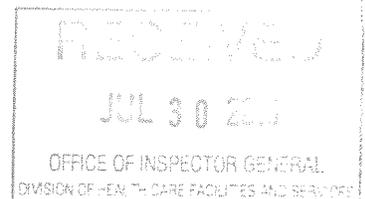
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F 309	<p>Continued From page 21</p> <p>2012 and now the facility would not allow the resident to go out of doors without staff supervision. Resident #3 stated not being allowed to go out of doors independently made him/her feel like a prisoner in the facility as he/she was an independent adult. The resident stated he/she had done a "foolish thing" by trying to back up into the gazebo out of doors and had caused the fall from his/her wheelchair on 06/07/13. The resident further stated he/she was not informed he/she was not to go out of doors alone until he/she went out of doors unsupervised on 06/15/13. Resident #3 indicated the facility staff upon seeing him/her out of doors on 06/15/13 returned him/her to the facility and just then informed the resident he/she could not go out alone. Resident #3 also stated it was okay with his/her physician's nurse practitioner (order dated 03/17/13) for him/her to go out of the facility without staff supervision. The resident's daughter (present during the individual interview with Resident #3) stated she had spoken to the Director of Nursing (DON) after the resident was returned to the facility on 06/15/13 and explained her parent just wanted to remain independent but the DON told her she did not care what the physician/nurse practitioner ordered.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 06/27/13 at 9:50 AM, revealed she had worked at the facility for six (6) months and she was familiar with Resident #3 going out of doors unsupervised during that time. CNA #6 stated she had never known Resident #3 to have a fall when out of doors or in the facility and she did not recognize any risk of a fall for the resident. CNA #6 also stated she had been informed the resident could no longer go out of doors alone by</p>	F 309	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur.</p> <p>As a permanent systemic change, audits of all charts will be performed by night shift nurses each day to ensure that any new physicians' orders have been transcribed. Results of audits will be provided to the ADON daily for review and necessary follow up. The ADON will address and correct any errors identified and perform appropriate staff education or recommend further process changes to the DON to ensure compliance. DON will receive copies of all new orders and perform random audits of 10 charts weekly to ensure that night has completed audits and all orders have been transcribed. Quarterly safety assessments will be completed by staff occupational therapist on all residents using electric wheelchairs and/or electric scooters. Results of the assessments will be provided to the interdisciplinary team for review and recommendation. Based upon assessments, appropriate safety interventions will be implemented. Facility policies on MD order transcription were reviewed and updated on 7/15/13 to reflect this change.</p>		



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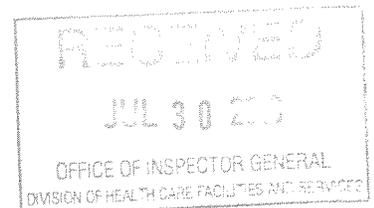
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F 309	Continued From page 22 the DON after the resident's fall on 06/07/13. She further stated Resident #3 was to be offered by staff to take him/her out of doors at 1:00 PM and 4:00 PM each day when they had time but she had not had time to do so in the past couple of weeks. Interview with CNA #7 on 06/27/13 at 10:13 AM revealed she had seen Resident #3 go out of doors many times by himself/herself and it had never been a problem until the resident had a fall from the electric wheelchair when out of doors. She stated she had not previously identified any concern or safety risk for Resident #3 to go out of doors alone but the DON had instructed the nursing staff Resident #3 was not to out of doors unsupervised anymore. Interview with RN #5 on 06/27/13 at 10:20 AM revealed he knew Resident #3 very well and was familiar with the resident going out of doors alone in the electric wheelchair. RN #5 stated he knew Resident #3 enjoyed sitting in the sun and people watching and felt it was good for the resident as the resident was depressed. RN #5 stated he was aware of a physician's order dated 06/13/13 which he transcribed on that date which stated Resident #3 was not to go out of doors without staff supervision. He further stated he was unaware Resident #3 had not been informed of that order. RN #5 indicated it was the responsibility of the nurse on duty at the time of a physician's order to transcribe the order to ensure necessary steps were taken to follow the order. He indicated he was not aware there was a physician's order for Resident #3 to go out of doors unsupervised on 06/17/13 and he did not know why that order was not transcribed. RN #5	F 309	How the facility plans to monitor its performance to ensure that solutions are sustained. Medical Records will audit 10% of charts monthly to ensure that all physician orders have been transcribed. Medical records will also audit all charts of residents using electric wheelchair/scooter to ensure that safety assessments have been performed. Results of the audits will be provided to the QA committee by the Director of Nursing monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.		



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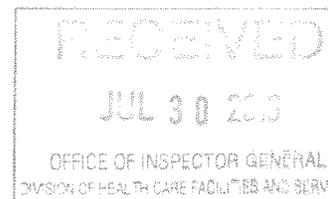
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F 309	Continued From page 23 revealed he had not Identified Resident #3 going out of doors alone in the electric wheelchair as a safety risk prior to the fall on 06/07/13. Interview with the Activity Director on 06/27/13 at 4:00 PM revealed she had seen Resident #3 out of doors alone many times and felt he/she enjoyed sitting in the sun and people watching. She stated she saw Resident #3 out of doors by the gazebo shortly before the resident's fall from the wheelchair on 06/07/13 but did not recognize any safety risk for the resident at that time. Interview with Assistant Director of Nursing (ADON) #2 on 06/27/13 at 10:50 AM revealed she was aware Resident #3 had gone out of doors independently since admission to the facility and was aware of the order for the resident to be supervised when going out of doors dated 06/13/13. She stated she thought the resident had been informed of that order prior to his/her going out alone on 06/15/13. ADON #2 further stated it was the responsibility of the nurse on duty to transcribe new physician orders and she did not know why the physician's order for Resident #3 to be allowed to go out of doors unsupervised on 06/17/13 was not transcribed. ADON #2 revealed she was aware of the facility policy regarding recognition of resident safety risks and environmental hazards but wasn't sure if staff were trained on that policy. She indicated no staff to her knowledge had identified a safety risk for Resident #3 to go out of doors alone in the electric wheelchair prior to his/her fall on 06/07/13 but stated it was a potential risk for any resident going out of doors alone in an electric wheelchair.	F 309			
F 323	483.25(h) FREE OF ACCIDENT	F 323			



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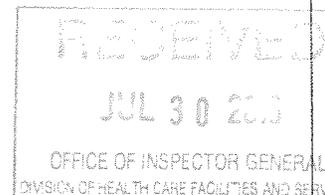
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F 323 SS=D	<p>Continued From page 24 HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review it was determined the facility failed to identify, evaluate and monitor accident risks to prevent the fall of an unsupervised resident from an electric wheelchair out of doors. Resident #3 fell from the electric wheelchair when unsupervised and out of doors on 06/07/13 causing a minor injury.</p> <p>The findings include:</p> <p>Review of the facility policy Safety and Supervision of Residents dated December 2011 revealed Our facility strives to make the environment as free from accident hazards as possible and #2 Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes.</p> <p>Review of Resident #3's clinical record revealed the facility admitted the resident on 01/14/12 with diagnoses to include Diabetes, Peripheral</p>	F 323	<p>323 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A safety assessment was performed on resident #3 by a staff occupational therapist on 6/28/13. The resident was found to be safe operating the electric wheelchair unsupervised.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. An assessment of all residents using electric wheelchairs and/or electric scooters was completed by a staff occupational therapist on 7/19/13. No new safety concerns were identified.</p>	7/28/13	



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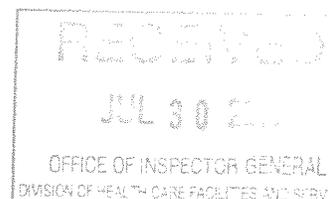
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F 323	<p>Continued From page 25</p> <p>Vascular Disease and Depression. Review of the initial nursing assessment dated 01/14/12 revealed Resident #3 used an electric wheelchair for mobility and further record review indicated the resident continued to do so independently until a fall from the wheelchair out of doors on 06/07/13. Review of the emergency department report of 06/07/13 revealed Resident #3 had an abrasion to the forehead requiring first aid only and a negative scan of the head. A review of the comprehensive nursing care plan for Resident #3 indicated a strength was the resident enjoyed going outside (unsupervised). . .dated 03/27/13. Review of the Minimum Data Set (MDS) (an assessment document for residents of long term care facilities) revealed the facility scored the resident as a fourteen (14) in cognition (intact cognition) on 01/03/13. Further review of the MDS revealed Resident #3 was self sufficient in the electric wheelchair.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 06/27/13 at 9:50 AM, revealed she had worked at the facility for six (6) months and was familiar with Resident #3 going out of doors unsupervised during that time. CNA #6 stated she had never considered Resident #3 as at risk for a fall from the electric wheelchair while out of doors unsupervised. However, she stated she now recognized it as a risk since he/she had a fall from the wheelchair while out of doors on 06/07/13. She further stated she did not remember being trained on a facility safety policy but was aware she should report any resident safety concerns to her charge nurse.</p> <p>Interview with CNA #7, on 06/27/13 at 10:13 AM, revealed she had seen Resident #3 go out of</p>	F 323	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. Quarterly safety assessments will be completed by staff occupational therapist on all residents using electric wheelchairs and/or electric scooters. Results of the assessments will be provided to the interdisciplinary team for review and recommendation. Based upon assessments, appropriate safety interventions will be implemented. Facility policies on Resident Safety have been reviewed and updated on 7/15/13 to reflect this change.</p>		



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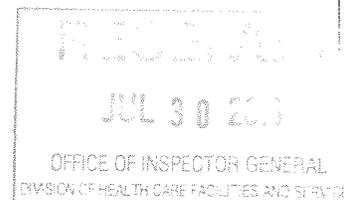
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F 323	<p>Continued From page 26</p> <p>doors many times by himself/herself and it had never been a problem until the resident had a fall from the electric wheelchair. She stated she had not previously identified any concern or safety risk for Resident #3 to go out of doors alone and did not remember specifically a facility policy on safety and supervision of residents. CNA #7 further stated she could now see it was a risk to have Resident #3 go out unsupervised in the electric wheelchair.</p> <p>Interview with RN #5, on 06/27/13 at 10:20 AM, revealed he knew Resident #3 very well and was familiar with the resident going out of doors alone in the electric wheelchair. RN #5 stated he knew Resident #3 enjoyed sitting in the sun and people watching and felt it was good for the resident as the resident was depressed. RN #5 revealed he had not identified Resident #3 going out of doors alone in the electric wheelchair as a safety risk prior to the fall on 06/07/13; however, he thought it was the resident's right to go out of doors alone. RN #5 indicated he thought the resident could be trained on wheelchair safety and still be allowed to go out independently.</p> <p>Interview with the Activity Director on 06/27/13 at 4:00 PM revealed she had seen Resident #3 out of doors alone many times and felt the resident enjoyed sitting in the sun and people watching. She stated she saw Resident #3 out of doors by the gazebo shortly before the resident's fall from the wheelchair on 06/07/13 but did not recognize any safety risk for the resident at that time.</p> <p>Interview with Assistant Director of Nursing (ADON) #2, on 06/27/13 at 10:50 AM, revealed she was aware Resident #3 had gone out of</p>	F 323	<p>How the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Medical Records will audit charts of resident using electric wheelchairs/scooters quarterly to ensure that safety assessments have been completed. Results of the audit will be provided to the QA committee by the Director of Rehab Services monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.</p>		



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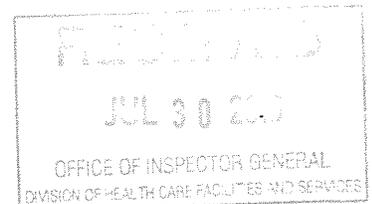
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 27 doors independently since admission to the facility. ADON #2 stated she had been in a meeting to discuss Resident #3's fall on 06/07/13 and the intervention planned was for Resident #3 to be supervised when going out of doors. She stated another intervention was for Resident #3 to be assessed for wheelchair mobility, but the assessment did not include safety awareness or potential for fall due to environmental hazards when out of doors. She stated no staff, to her knowledge, had identified a safety risk for Resident #3 to go out of doors alone in the electric wheelchair prior to his/her fall on 06/07/13 and she stated it was a potential risk for any resident going out of doors alone in an electric wheelchair. Interview with the Administrator, on 06/27/13 at 4:00 PM, revealed he was aware of Resident #3's fall from the electric wheelchair on 06/07/13. He was aware the resident was unsupervised and was aware the resident had no identified safety risks prior to the fall. The Administrator stated the facility had probably not completed an adequate assessment for Resident #3 to prevent his/her fall.	F 323	F368 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Snacks were made available to all residents on two (2) of two (2) nursing units by the food service director and distributed by nursing staff on 6/28/13. How the facility will identify other residents having the potential to be affected by the same deficient practice. A review by the food service director on 7/5/13 of ordered snacks, supplements, and dietary alternatives found that 53 residents were potentially affected by this deficient practice. Snacks were made available each evening to all 53 affected residents beginning 7/5/13 via a snack cart distributed by nursing assistants on duty.	7/28/13	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.	F 368			



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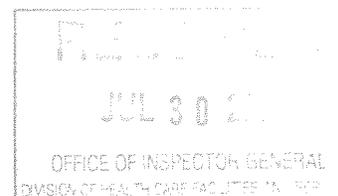
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F 368	<p>Continued From page 28</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to offer all residents on two (2) of two (2) nursing units (who did not receive labeled house supplements) daily bedtime snacks.</p> <p>The findings include:</p> <p>Review of the facility's policy Frequency of Meals, review date 12/2011, revealed evening snacks would be available to all residents. The facility would offer snacks if the time span between the evening meal and the next day's breakfast exceed fourteen (14) hours.</p> <p>Interview with Unsampled Resident D, on 06/25/13 at 8:45 AM, during initial tour revealed the resident was not offered any bedtime snacks.</p> <p>Interview with Resident Council Group, on 06/25/13 at 3:00 PM, revealed residents could ask for a bedtime snack but no snacks were offered. The group stated it would be nice to have snacks offered.</p> <p>Interview with Resident #5, on 06/27/13 at 3:30 PM, revealed he/she was not offered a bedtime</p>	F 368	<p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. Snack distribution has been assigned to the nurses during their evening med pass. The snacks are stored on the health care center units in baskets that the nurses will place on the med carts. During the evening med pass all residents will be asked by the nurse if they would like a snack. This process has been added to the MAR and the nurse will document acceptance or denial of the snack. All nurses were educated by the DON and food service director on this new systemic change on 7/15, 7/17, and 7/18.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained. An audit of 5% of MARS will be completed monthly by medical records to ensure sign off of snack distribution. Results of the MAR audit will be provided to the DON for follow up and resolution of noncompliance. The Food Service Director will also audit snack distribution to nursing units weekly to ensure snack are made available for distribution to residents. Results of the audit will be provided to the QA committee monthly by the DON and Food Service Director for review and recommendation.</p>		



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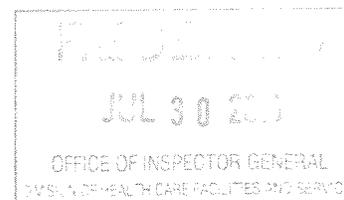
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F 368	Continued From page 29 snack and sometimes he/she would give staff money to go out to buy coffee-flavored yogurt, especially during the Basketball Tournament, when he/she stayed up later. Interview with Resident #10, on 06/27/13 at 9:30 AM, revealed the resident had not been offered a bedtime snack by facility staff at any time since admission and indicated a snack would be nice. Interview with Resident #11, on 06/27/13 at 11:10 AM, revealed the resident had not been offered a bedtime snack by facility staff at any time since admission. The resident stated a snack would be welcome. Interview with Resident #12, on 06/27/13 at 1:10 PM, revealed the facility staff had not offered the resident a bedtime snack of real food. The resident stated a health drink was offered once. Interview with the Dietary Director, on 06/27/13 at 3:08 PM, revealed a bedtime snack did not have to be offered to residents unless there was greater than fourteen (14) hours between supper and breakfast.	F 368	Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes. F371 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The food service director purchased a new enclosed rack for storage of dishes which has been put into place allowing for dishes to be stored in compliance with regulation. The hand washing sink has been reattached to the wall and caulking replaced by maintenance staff. A new trash can with an attached lid has been purchased and the old can removed by food service director. The ice cream freezers have been removed from use. Ice cream is now stored in the freezer portion of a self defrosting refrigerator/freezer which was already present on both floors of the health care center. All the above items were completed by 7/5/13.	7/29/13	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			



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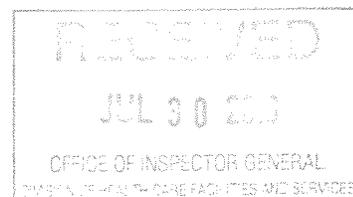
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F 371	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy, it was determined the facility failed to ensure dishes used for food were stored under sanitary conditions, that hand washing facilities were clean and in good repair, and that an ice cream freezer was maintained to ensure food was kept at an acceptable temperature. Dishes used to serve food were stored bowl side up and not inverted. The hand washing sink was pulling away from the wall and the caulking around the sink was cracked and pieces were missing. The ice cream freezer on the second floor had a heavy layer of frost on the inside freezer walls.</p> <p>The findings include:</p> <p>The facility did not provide policies for storage of dishes, maintaining the cleanliness of the trash can next to the hand sink, or defrosting the ice cream freezer on the second floor.</p> <p>Observation of the kitchen, on 06/25/13 at 8:10 AM, revealed the hand washing sink was pulling away from the wall and the caulking between the sink and the wall was cracked and pieces were missing. The trash can next to the hand sink was heavily soiled with drips and dark particles on the outside. Dishes were stored on wire shelving bowl side up and uncovered. The second floor ice cream freezer had a heavy build-up of frost on the walls.</p> <p>Interview with the Dietary Director, on 06/27/13 at 3:20 PM, revealed he was not aware that clean dishes were to be stored covered or inverted. He</p>	F 371	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice. A sanitation audit was performed by our consultant dietician on 7/8/13. No further concerns were identified.</p> <p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. Dietary staff was educated by the Food Service Director on sanitation on 7/16/13. A twice weekly kitchen compliance audit will be performed by the Food Service Director. The consultant dietician will perform weekly sanitation audits of the kitchens and the healthcare center dining rooms. The results of these audits will be provided to the Administrator for review and follow up. Any identified issues will be corrected immediately.</p>	



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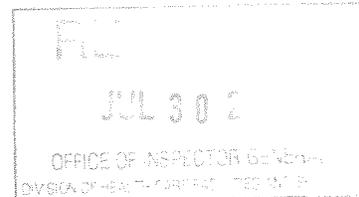
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F 371	Continued From page 31 stated the hand sink was repaired by maintenance and the trash can next to the hand sink would be cleaned. This would prevent the spread of germs. He stated the ice cream freezer should be cleaned monthly to ensure the freezer functioned correctly.	F 371	How the facility plans to monitor its performance to ensure that solutions are sustained. Results of the twice weekly kitchen compliance audits and weekly sanitation audits will be presented to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly for six (6) months. The QA committee will continue to review the audits and make further recommendation based upon outcomes.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents had full access to the emergency call light system in ten (10) resident restrooms on three (3) of four (4) resident hallways. The findings include: Observation, on 06/25/13 at 8:25 AM, during the initial tour of the facility revealed the extension string for the emergency call light next to the toilet in resident room 250 was missing. Observation, on 06/26/13 at 2:30 PM, revealed missing emergency call light extension strings by the toilets in resident rooms 131, 135, 137, 231, 234, 239, 242, 246, 251, and 260. Interview, on 06/27/13 at 1:30 PM, with the Director of Maintenance and Environmental Services, revealed monthly room audits were conducted to check call lights, emergency call	F 463	F463 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Call light extension strings were placed in resident rooms 131, 135, 137, 231, 234, 239, 242, 246, 251, and 260 by the Maintenance Director on 6/28/13. How the facility will identify other residents having the potential to be affected by the same deficient practice. A review of all resident rooms was completed by the Maintenance Director on 6/28/13 and no other call light extension strings were found missing.	7/19/13



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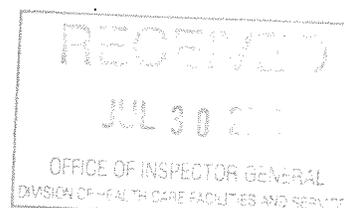
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F 463	Continued From page 32 lights, lighting, and cleanliness of all residents' rooms. Logs were kept that documented the monitoring and he would provide a copy of this documentation. The Director of Maintenance and Environmental Services stated the problem with not having the extension strings attached to the call lights would be that a resident may not be able to reach the emergency call light to summon help if he/she had fallen to the floor. Review, on 06/27/13 at 1:50 PM, of the Health Care Safety Audits (dated 06/18/13) provided by the Director of Maintenance and Environmental Safety, revealed a section labeled call lights, but it was unclear if this included the emergency call lights in the residents' restrooms. Interview, on 06/27/13 at 2:10 PM, with the Director of Maintenance and Environmental Safety revealed the category labeled call lights on the facility's monthly audit sheets did include monitoring of the emergency call lights in the residents' restrooms, but he thought a category should be added that would be specific to checking the restroom emergency call lights.	F 463	What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. Housekeeping staff will audit all rooms daily to ensure that overbed light extension strings are in place. Any identified issues will be reported to maintenance immediately for resolution. Housekeeping staff will submit daily audits to maintenance director on a weekly basis. The maintenance staff will audit rooms monthly to validate housekeeping findings. Monthly maintenance audits will be submitted to the Administrator for review and appropriate follow up. How the facility plans to monitor its performance to ensure that solutions are sustained. Maintenance Director will submit results of the audits to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly. The QA committee will continue to review the audits and make further recommendation based upon outcomes.		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465			



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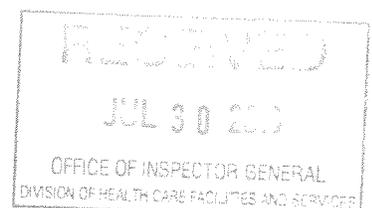
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F 465	<p>Continued From page 33</p> <p>by: Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents evidenced by five (5) overbed call light pull cords too short and could not be reached by residents.</p> <p>The findings include:</p> <p>Observation, on 06/25/13 at 8:30 AM, during initial tour of the facility revealed the overbed lights in rooms 242-A, 250-B, 252-B, and 254-A and 254-B had a pull chain of about 3 inches, but the extension string was missing that would allow residents to turn the light on from a sitting position while in bed.</p> <p>Interview, on 06/26/13 at 3:10 PM, with Unsampled Resident F, revealed he/she usually turned the overbed light on using the on/off switch on the wall next to the entry door to his/her room, but it would be nice to have an extended length pull chain so he/she would not have to get up from the bed to turn the light off and on.</p> <p>Interview, on 06/27/13 at 1:30 PM, with the Director of Maintenance and Environmental Services revealed monthly room audits were conducted to check call lights, room lighting, emergency call lights, and cleanliness of all residents' rooms. He stated he would provide logs that documented the monthly monitoring.</p> <p>Review, on 06/27/13 at 1:50 PM, of the Health Care Safety Audits provided by the Director of Maintenance and Environmental Services did not reveal a category specific to checking the function</p>	F 465	<p>F465 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Extension strings were added to overbed lights in rooms 242-A, 250-B, 252-B, 254-A, and 254-B by the Maintenance Director on 6/28/13.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. A review of all rooms was completed by the Maintenance Director on 6/28/13 and no other overbed light extension strings were found missing.</p> <p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. Housekeeping staff will audit all rooms daily to ensure that overbed light extension strings are in place. Any identified issues will be reported to maintenance immediately for resolution. Housekeeping staff will submit daily audits to maintenance director on a weekly basis. The maintenance staff will audit rooms monthly to validate housekeeping findings. Monthly maintenance audits will be submitted to the Administrator for review and appropriate follow up.</p>	7/19/13	



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F 465	Continued From page 34 of the overbed lights in residents' rooms.	F 465	<p>How the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Maintenance Director will submit results of the audits to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly. The QA committee will continue to review the audits and make further recommendation based upon outcomes.</p>		



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: Two (2) stories and a Basement, Type II Unprotected.</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments on each floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/26/13. Westminster Terrace was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest deficiency identified at E level.</p>	K 000		

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

TITLE

(X6) DATE

[Signature]

X Executive Director

X 7/19/13

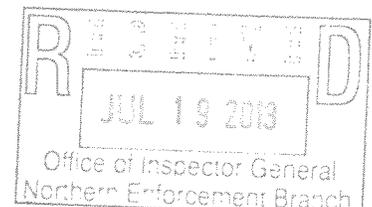
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

If continuation sheet Page 1 of 6
Office of Inspector General
Northern Enforcement Branch

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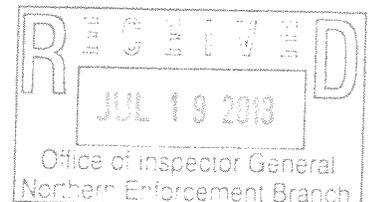
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K 062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has one hundred and twelve (112) certified beds and the census was eighty-eight (88) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/26/13 at 9:45 AM, with the Director of Environmental Services revealed the First Floor Lounge/Dining Area did not have an escutcheon plate installed on two (2) of the ceiling sprinkler heads. Escutcheon plates are required to prevent smoke from entering the space above the ceiling in the event of an emergency.</p> <p>Interview, on 06/26/13 at 9:45 AM, with the Director of Environmental Services revealed he was unaware of the two (2) escutcheon plates missing from the ceiling sprinkler heads.</p>	K 062	<p>K062 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Director of Maintenance replaced the two escutcheon plates in the First Floor Lounge/Dining Area on 6/27/13.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. A safety review of the facility was completed on 6/27/13 by the Maintenance Director. No further missing escutcheon plates were found.</p> <p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. The Maintenance Director will complete a facility safety review monthly which includes checking for escutcheon plates. Any identified concerns will be corrected immediately. The results of the safety review will be submitted to the Administrator for further action.</p>	7/19/13



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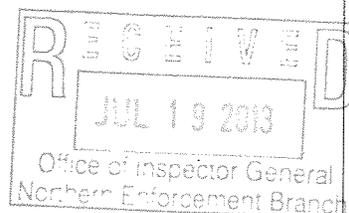
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2013
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, 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 062	Continued From page 2 Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062	How the facility plans to monitor its performance to ensure that solutions are sustained. Maintenance Director will submit results of the safety reviews to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly. The QA committee will continue to review the audits and make further recommendation based upon outcomes.	



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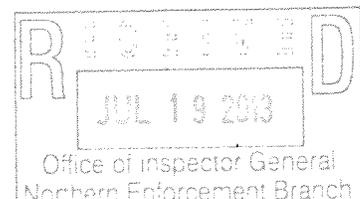
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/26/2013
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, 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 130 SS=D	<p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of the six (6) smoke compartments, approximately fifteen (15) residents, staff, and visitors. The facility has one-hundred and twelve (112) certified beds and the census was eighty-eight (88) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/26/13 at 9:00 AM, with the Director of Environmental Services revealed an unapproved lock (slide bolt type) was installed on the egress side of the door from the shared toilet room between Resident Rooms 238 and 239.</p> <p>Interview, on 08/26/13 at 9:00 AM, with the Director of Environmental Services revealed he was unaware of the slide bolt lock being installed on the door and indicated it may have been put on by the resident's family. He agreed that slide bolt locks could be a deterrent to exiting the room in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 Edition)</p>	K 130	<p>K130</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The unapproved lock (slide bolt type) was removed on 6/28/13 by the Director of Maintenance from the egress side of the door in a shared bathroom between resident rooms 238 and 239.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>A safety review of the facility was completed on 6/27/13 by the Maintenance Director. No further unapproved locks were found.</p> <p>What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur.</p> <p>The Maintenance Director will complete a facility safety review monthly which includes checking for unapproved locks. Any identified concerns will be corrected immediately. The results of the safety review will be submitted to the Administrator for further action.</p>	7/19/13



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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 130	Continued From page 4	K 130	<p>How the facility plans to monitor its performance to ensure that solutions are sustained. Maintenance Director will submit results of the safety reviews to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly. The QA committee will continue to review the audits and make further recommendation based upon outcomes.</p> <p>K147 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The power strip was removed from resident room 134 by the Director of Maintenance on 6/27/13.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. A safety review of the facility was completed on 6/27/13 by the Maintenance Director. No further power strips were found.</p>	7/19/13	
K 147 SS=D	<p>19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of (6) smoke compartments, approximately ten (10) residents, staff, and visitors. The facility has one-hundred and twelve (112) certified beds and the census was eighty-eight (88) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/26/13 at 9:35 AM, with the Director of Environmental Services revealed the resident's personal refrigerator located in Room 134, was plugged into a power strip.</p> <p>Interview, on 06/26/13 at 9:35 AM, with the Director of Environmental Services revealed he was aware of the requirements for the usage of power strips; however, he was not aware of a refrigerator being plugged into a power strip in the</p>	K 147			



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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
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K 147	Continued From page 5 resident's room. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. The Maintenance Director will complete a facility safety review monthly which includes checking for power strips. Any identified concerns will be corrected immediately. The results of the safety review will be submitted to the Administrator for further action. How the facility plans to monitor its performance to ensure that solutions are sustained. Maintenance Director will submit results of the safety reviews to the QA committee monthly for review and recommendation. Once 100% compliance has been achieved for three (3) consecutive months, the audits will be reduced to quarterly. The QA committee will continue to review the audits and make further recommendation based upon outcomes.		

