

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

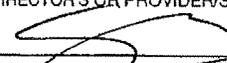
PRINTED: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 06/26/2014
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 000	INITIAL COMMENTS A Standard Health survey was conducted from 06/24/14 through 06/26/14. Deficiencies were cited with the highest scope and severity of an "F".	F 000	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, the 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.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on review of the survey result binder and interview, it was determined the facility failed to have survey results available for examination in a place readily accessible to residents and visitors. The findings include: Record review of the survey book located in the front lobby, on 6/24/14 at 9:00 AM, revealed the abbreviated survey conducted in June 2013 that determined eleven (11) deficiencies existed were not in the survey result binder. Interview with the Assistance Administrator, on 6/26/14 at 9:00 AM, revealed she did not realize the survey results were not in the survey binder.	F 167	What corrective action will be accomplished for those residents found to be affected by the deficient practice: Results with plan of correction for the June 2013 abbreviated survey were placed in the survey result binder by the Community Director on 6/24/14. This binder was replaced in the lobby of the Health & Rehab Center after the conclusion of the current survey on 6/26/14. The Social Services Director will inform residents in the Resident Council on 7/29/14 that updated survey results are available to them in the binder in the lobby, and that they may use the magnifying reader in the activity room as needed. Signage is already in place in the lobby informing the public that survey results are available for viewing.	7/29/14 7-30-14 pu c g Dy PB 7-21-14

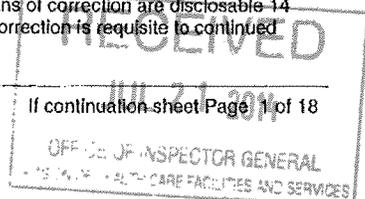
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

X  X Exec Dir X 7/18/14

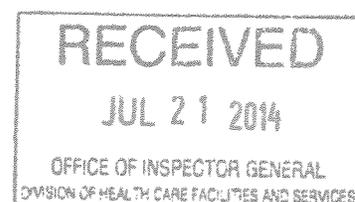
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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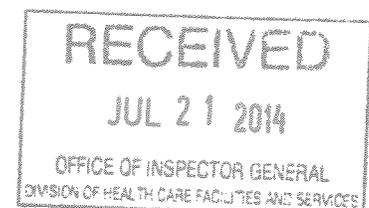
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F 167 F 282 SS=D	Continued From page 1 She stated the Administrator was took care of the binder, and he was currently was out of town. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review it was determined the facility failed to follow the plan of care for one (1) of seventeen (17) residents as it related to Resident #1's contact isolation for infectious stool. The findings include: Review of the Comprehensive Care Plan policy, reviewed December 2011, revealed each residents comprehensive care plan was designed to incorporate identified problem areas and reflect currently recognized standards of practice for problem areas and conditions. Record review of Resident #1's record, revealed Resident #1 was re-admitted on 06/18/14, with a diagnosis of Septic Shock, Infectious Diarrhea in Adult Patient, Complicated Urinary Tract Infection and Acute Renal Failure. Record review of Resident #1's Physician Orders, dated 06/18/14, revealed Resident #1 was ordered Contact Isolation related to loose stool and antibiotic therapy.	F 167 F 282	How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents were affected by the deficient practice. See above response for corrective actions. Upon receipt of the statement of deficiencies and/or approval of the plan of correction (when applicable), the Executive Director will give these documents to the Administrative Assistant for placement in the survey results binder located in the facility lobby. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Executive Director, will check the survey results binder monthly to ensure that the most recent results are present. This will be a permanent, systemic change to be completed quarterly. Any missing results will be reported to the Executive Director and corrected immediately. How the facility plans to monitor its performance to ensure that solutions are sustained: The Executive Director will report to the QA committee on presence of the most recent survey results in the lobby binder. This report will be given monthly for at 6 months or until compliance is achieved for 3 consecutive months. Further action will be based upon QA committee recommendation.		



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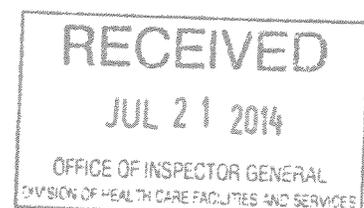
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F 282	Continued From page 2 Record review of Resident #1's Diarrhea and Contact Isolation Care Plan, revealed the goal for Resident #1, was to not have any complications from diarrhea. Resident #1's approach was to follow contact isolation for infectious diarrhea. Observation of Certified Nursing Assistant (CNA) #1, on 06/24/14 at 2:36 PM, revealed CNA #1 entered Resident #1's room, and did not don any Personal Protective Equipment (PPE). Observation of CNA #1, on 06/24/14 at 2:40 PM, revealed CNA #1 beside Resident #1's bed, change Resident #1's brief with no gown on. CNA #1 was observed to have gloves on. Interview with CNA #1, on 06/24/14 at 2:53 PM, revealed she was aware Resident #1 was on Contact Isolation. CNA #1 stated she talked with the nurse who informed her that Resident #1 did not have C-Diff. CNA #1 stated she did not wear a gown because she had an allergy to the isolation gowns, though she did use gloves when she provided incontinent care to Resident #1. CNA #1 stated she was aware that when a resident was diagnosed with C-Diff, she was to wear a gown and gloves, and to wash her hands when she exited the room. CNA #1 stated the gowns were worn so that C-Diff could not be transmitted to clothes. CNA #1 stated she should have informed the nurse that she was allergic to the isolation gowns, and that she did not bring an extra pair of clothing to work that day. Observation of CNA #3, on 06/24/14 at 3:15 PM, revealed CNA #3, passing ice and stopped at Resident #1's room. CNA #3 then walked into Resident #1's room without donning gloves or	F 282			



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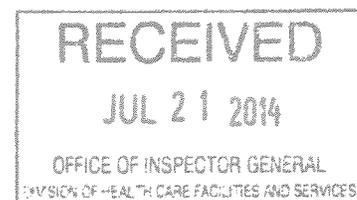
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F 282	Continued From page 3 gown and brought out Resident #1's water pitcher, and placed the water pitcher on the ice cart. CNA #3 then placed ice into the water pitcher and put the water pitcher back into Resident #1's room. Interview with CNA #3, on 06/24/14 at 3:15 PM, revealed she was not aware she did not follow contact precautions for Resident #1. CNA #3 stated if she did not follow contact precautions then she did not follow the care plan for Resident #1. Interview with Registered Nurse (RN) #2, on 06/26/14 at 11:05 AM, revealed the nursing staff initiated the care plan. RN #2 stated she could also update the care plan when new orders were written. Resident #1's Contact Isolation should be on the care plan. The plan of care needed to be followed for each resident to ensure the proper care was given. Interview with the Minimum Data Set (MDS) Coordinator, on 06/26/14 at 2:15 PM, revealed care plans were initiated upon admission and then updated with the initial assessment, quarterly and significant changes assessments. The MDS Coordinator stated the nurses placed the orders on to the care plan and then placed a copy onto the twenty-four (24) hour report. The MDS Coordinator stated when a plan of care was provided she expected the staff to follow the plan of care. The interdisciplinary team developed the care plan to provide the best care to each resident. Interview with the Director of Nursing (DON), on 06/26/14 at 1:29 PM, revealed any nurse could initiate the plan of care upon admission. The	F 282	F 282 What corrective action will be accomplished for those residents found to be affected by the deficient practice: CNA #1 and CNA #3 were in-serviced by the Director of Nursing on 6/24/14 regarding following isolation precautions and using protective equipment per resident care plan. CNA #3 was in-serviced on procedure of passing ice to resident in isolation. After being made aware of CNA #1 allergy to facility stocked isolation gowns, a different type of gown was obtained on 6/24/14 from vendor. All direct-care staff working in facility on 6/24/14 and 6/25/14 were educated while on duty about following isolation precautions per resident care plan by Director of Nursing (DON), Assistant Director of Nursing (ADON), and weekend nurse supervisor. CNA care guide for Resident #1 was amended on 6/24/14 by DON and MDS Coordinator to include contact isolation precautions. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 6/24/14, the Director of Nursing, Assistant Director of Nursing, and MDS coordinator reviewed all residents' care plans on isolation, and all care plans were found to include appropriate instructions to staff about isolation precautions.	7/18/14	



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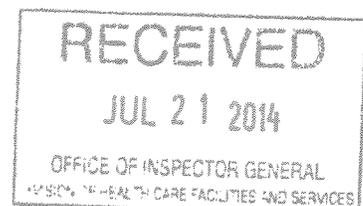
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F 282	Continued From page 4 MDS Coordinator completed the comprehensive care plan. The DON stated the care plans were also updated based on the physician orders. The DON stated the staff did not follow the care plan as outlined. Staff were expected to follow the plan of care to ensure the residents were taken care of appropriately.	F 282	Nursing staff were educated on facility policy regarding Resident Plan of Care and the CNA Care Guide on 7/11/14 – 7/16/14. Upon receipt of new orders and/or change in resident plan of care, the nurse will perform a handwritten update to the resident care plan and CNA care guide to reflect the change. The nurse will educate the CNAs of changes in the plan of care at the time they are initiated and communicate to appropriate ancillary departments as needed.. In addition, the nurse will note the changes to the plan of care. The nurse will notify the DON, ADON and MDS Coordinator via 24 hour report of the changes in the plan of care. The MDS Coordinator will generate a new, printed care plan and CNA care guide containing new orders and/or provisions of care within 72 hours of notification. The updated care plan will be placed on the resident's chart and the updated CNA care guide will be placed inside the resident closet in the resident room.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's policies Sanitization and Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices it was determined the facility failed to serve food in a sanitary manner in two (2) of the two (2) facility dining rooms. Food service aides were observed to touch food with gloved hands after they left the tray line and touched multiple surfaces. In addition, the residents' food was observed being served on wet trays, and the first floor food server used inappropriate hand hygiene. The findings include:	F 371	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Assistant Director of Nursing and MDS Coordinator will conduct audits of any new orders within 72 hours of receipt to ensure they are care planned, and communicated to other staff as noted above. Audits will be weekly for 1 month, then bi-monthly for 3 months until 100% compliance is		



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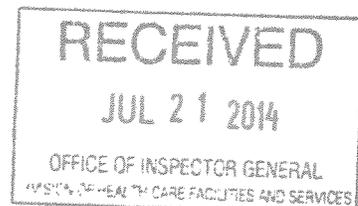
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F 371	<p>Continued From page 5</p> <p>Review of the facility's policy Sanitization, revised 07/10/12, revealed food preparation equipment and utensils that are manually washed will be allowed to air dry.</p> <p>Review of the facility's policy Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised December 2011, revealed food service employees should follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. Gloves were considered single-use items and must be discarded after completing the task for which they were used. The use of disposable gloves does not substitute for proper handwashing.</p> <p>1. Observation of the afternoon meal, on 06/25/14 at 12:05 PM, revealed Food Service Aide #1 washed her hands and then used her bare hands to touch the handle of paper towel dispenser to obtain a paper towel.</p> <p>Continued observation of the tray line from the steam table in the first floor dining room, on 06/25/14 at 12:08 PM, revealed Food Service Aide #1 used gloved hands to touch the meal tickets and then spread them out on the top of the steam table. Without changing gloves, the Food Service Aide then used her gloved hands to separate and serve dinner rolls. At 12:25 PM, the Food Service Aide left the tray line to obtain items from the refrigerator and tea bags from the cabinet. The Food Service Aide returned to the tray line and did not change gloves or perform hand hygiene. The Food Service Aide continued</p>	F 371	<p>obtained in 3 consecutive audits.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained: DON will report results of audits to QA committee monthly for 4 months or until the committee is satisfied that systemic problems have been corrected.</p> <p>F 371</p> <p>What corrective action will be accomplished for those residents found to be affected by the deficient practice: Food Service Director educated food service staff on duty on 6/24/14 about proper glove usage, hand washing, cross contamination, and the facility policy related to air-drying trays.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice: DON and ADON have monitored for the occurrence of gastrointestinal symptoms among residents for 72 hours to determine whether deficiency in sanitary food service practices may have contributed to these occurrences.</p>	



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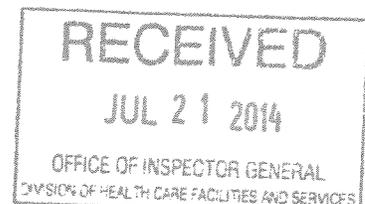
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F 371	<p>Continued From page 6</p> <p>to serve food and used her contaminated gloved hands to serve the bread rolls.</p> <p>Observation of the utensils stored by the steam table, on 06/25/14 at 12:45 PM, revealed there were no longs for use.</p> <p>Interview with Food Service Worker #1, on 06/25/14 at 12:45 PM, revealed she always used her hands to serve the bread and the bacon. The Food Service Worker revealed she was aware of a potential risk for cross-contamination, but stated the bacon is too crispy and the bread stuck together. The Food Service Worker revealed she was aware she left the tray line and used her gloved hands to touch several different surfaces, but did not think to change her gloves.</p> <p>2. Observation of the morning meal service in the first floor dining room, on 06/24/14 at 8:45 AM, revealed several wet trays were stored ready for use by the steam table. When picked up for use, the Food Service Aide told Certified Nursing Assistant (CNA) #4 the trays were wet. The CNA was observed to pick up a cloth towel lying next to the steam table and wiped them down then continued to use the trays.</p> <p>Observation of the afternoon meal, on 06/25/14 at 12:17 PM, revealed several wet trays used to serve food to residents.</p> <p>Interview with CNA #4, on 06/26/14 at 1:45 PM, revealed she had seen trays stored wet in the dining room on multiple occasions. The CNA revealed she usually wiped them off and used them despite being stored wet. The CNA revealed she did not know of a potential cross-contamination with the trays being stored</p>	F 371	<p>No signs or symptoms of infection have been noted with any residents. Food Service Director provided education to dietary staff on 7/3/14 on proper glove usage, proper hand washing, cross-contamination, and air-drying trays and other dishes in the dish room before bringing them to the dining rooms. Director of Environmental Services supplier will provide touchless/automatic paper towel dispensers for meal service areas on 7/21/14. .</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>Food Services Director will observe service of 2 meals per week in dining rooms, varying times and floors, watching for appropriate sanitary practices. If 100% compliance is achieve after 1 month, Food Services Director will observe 1 meal per week for 2 months or until 100% compliance with sanitary practices is achieve for 3 consecutive weeks.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>Consultant dietician will also continue to observe one meal service per month for sanitary practices and will report observations to Food Service Director and Executive Director. Food Services Director will report monthly to the QA committee on results of observations and audits for at least 3 months or until the committee is satisfied that systemic problems have been corrected.</p>	<p>7/21/14</p> <p>7-22-14 pncg</p> <p>RJPB 7-21-14</p>



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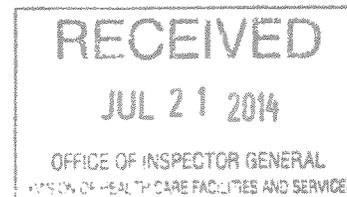
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F 371	<p>Continued From page 7 wet and had not received any training.</p> <p>Interview with the Food Service Director, on 06/26/14 at 1:18 PM, revealed proper hand washing techniques was not included in the training for the kitchen staff. The Food Service Director revealed food should not be served on wet trays due to the potential for cross-contamination. The Food Service Director revealed kitchen staff were trained on how to dry the trays and he monitored for proper sanitation procedures. However, the Food Service Director revealed the nursing staff were not trained and did not know wet trays should not be used. The Food Service Director revealed he monitored tray line once a week and did know the servers used gloved hands to serve food and had witnessed staff perform glove changes after having touched other surfaces. The Food Service Director revealed it was a cross contamination issue when servers continued to serve food with gloved hands that had been in contact with multiple surfaces.</p> <p>3. Observation of the breakfast meal, on 06/24/14 at 8:27 AM, revealed Food Service Worker #1, touched bacon and bread with gloved hands. Then with the same gloved hands touched the meal tickets and cabinets in the kitchen. Food Service Worker #1 did not use tongs for bacon and bread, and continued this process throughout the meal.</p> <p>Continued observation of the breakfast meal, on 06/24/14 at 8:30 AM, revealed Food Service Worker #1 grabbed a pancake out of the warmer with the same gloved hands. Food Service Worker #1 then touched the refrigerator handle to</p>	F 371			



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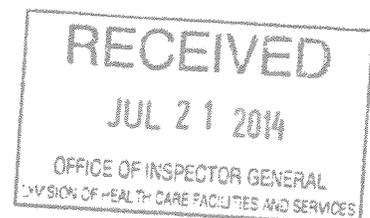
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F 371	Continued From page 8 take out a yogurt. The Food Service Worker #1 then took out bacon and bread with the same gloved hands. Observation of the breakfast meal, on 06/24/14 at 8:40 AM, revealed Food Service Worker #1 picked up a pancake from warmer with same gloved hands and placed the pancake back into the warmer. Food Service Worker #1 did not remove her gloves nor did she wash her hands during the observations. 4. Observation during the lunch meal service on the second floor, on 06/25/14 at 12:30 PM, revealed Food Service Aid #2 with gloved hands, leave the tray line area and opened a cabinet door to retrieve a bag that contained a loaf of bread; opened the plastic bag and with the same gloved hand reached into the bag to pull out one slice of bread and placed onto a resident's plate. She then returned to the tray line to plate food for the facility residents without glove removal and hand washing. In addition the Food Service Aid was also observed to use the same gloved hands to break hot rolls apart and place onto the resident's plates. Attempted to interview Food Service Aid #2, on 06/26/14 at 5:00 PM, revealed she was not in the building nor available by phone for interview.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441			



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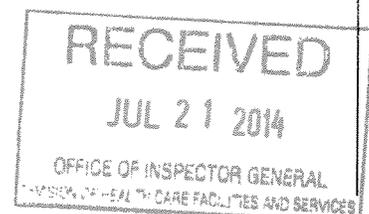
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F 441	<p>Continued From page 9 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to maintain an infection control program for one (1) of seventeen (17) residents; resident #1</p>	F 441		



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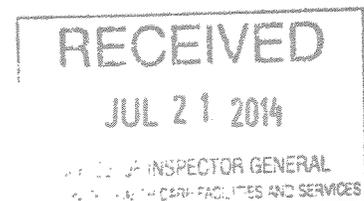
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F 441	<p>Continued From page 10</p> <p>as it related to his/her contact isolation. A staff member was observed to enter Resident #1's room without wearing Personal Protective Equipment (PPE), and provided incontinent care and passed ice. A staff member was observed to retrieve a nutritional drink from Resident #1's room and placed it into a refrigerator. In addition, one (1) of two (2) ice machines were observed to have scoops lying on top of the ice machine.</p> <p>The findings include:</p> <p>Review of the Isolation Categories of Transmission Based Precautions Policy, revised December 2011, revealed in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganism, that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Wear gloves when entering the room. Wear a gown for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand hygiene before leaving the residents environment.</p> <p>1. Record review of Resident #1's record, revealed Resident #1 was re-admitted on 06/18/14, with a diagnosis of Septic Shock, Infectious Diarrhea in Adult Patient, Complicated Urinary Tract Infection and Acute Renal Failure.</p> <p>Record review of Resident #1's Discharge Summary from the Hospital, dated 06/18/14 revealed, Resident #1 was placed on antibiotics and probiotics secondary to the development of loose stool. The stool studies were sent to a</p>	F 441	<p>F 441</p> <p>What corrective action will be accomplished for those residents found to be affected by the deficient practice:</p> <ol style="list-style-type: none"> 1. CNA #1 and CNA #3 were in-serviced by the Director of Nursing on 6/24/14 regarding following isolation precautions and using protective equipment as ordered. CNA #3 was in-serviced on procedure of passing ice to resident in isolation. 2. After being made aware of CNA #1 allergy to facility stocked isolation gowns, a different type of gown was obtained on 6/24/14 from vendor. 3. All direct-care staff working in facility on 6/24/14 and 6/25/14 were educated while on duty about isolation precautions by Director of Nursing (DON), Assistant Director of Nursing (ADON), and weekend nurse supervisor. 3. CNA #2 removed Boost from refrigerator immediately after interview with surveyor. Refrigerator was emptied and cleaned by food services staff on 6/24/14. 4. Ice machine and ice cooler were emptied and cleaned by Food Service Director on 6/24/14. Scoop was also sanitized at this time. 	7/18/14	



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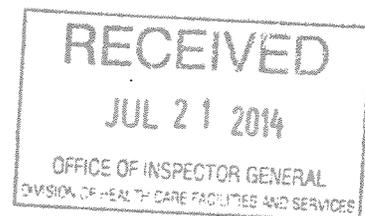
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F 441	Continued From page 11 diagnostic laboratory and the results were negative for Ova and Parasites, Clostridium Difficile (C-Diff) and Enteropathic Organisms. Record review of Resident #1's Physician Orders, dated 06/18/14, revealed Resident #1's was ordered Contact Isolation related to loose stool and antibiotic therapy. Observation of Certified Nursing Assistant (CNA) #1, on 06/24/14 2:36 PM, revealed CNA #1 entered Resident #1's room and did not don any Personal Protective Equipment (PPE). Observation of CNA #1, on 06/24/14 at 2:40 PM, revealed CNA #1 with no isolation gown on, change Resident #1's brief. CNA #1 was observed to have gloves on. Interview with CNA #1, on 06/24/14 at 2:53 PM, revealed she was aware Resident #1 was on Contact Isolation. CNA #1 stated she talked with the nurse who informed her that Resident #1 did not have C-Diff. CNA #1 stated she did not wear a gown because she had an allergy to the isolation gowns, though she did use gloves when she provided incontinent care to Resident #1. CNA #1 stated she was aware that when a resident was diagnosed with C-Diff, she was to wear a gown and gloves, and to wash her hands when she exited the room. CNA #1 stated the gowns were worn so that C-Diff could not be transmitted to clothes. CNA #1 stated she should have informed the nurse that she was allergic to the isolation gowns, and that she did not bring an extra pair of clothing to work that day. Interview with Registered Nurse (RN) #1, on 06/24/14 at 3:00 PM, revealed she informed CNA	F 441	How the facility will identify other residents having the potential to be affected by the same deficient practice: DON and ADON monitored all new infections for 72 hours from the date of the incident with Resident #1 to determine whether deficiency in staff infection control practices may have contributed to occurrence of infections. No new infections were noted. All facility staff were educated on 7/11/14 – 7/16/14 by the Director of Nursing and/or Assistant Director of Nursing regarding following isolation precautions, use of personal protective equipment, hand hygiene, items brought into and out of isolation rooms, and passing ice to isolation rooms. Food Services Director educated all staff on sanitation precautions for ice machines and hand hygiene before feeding residents in the same in-services trainings. Any deficient practices were corrected immediately. ADON reviewed and revised orientation curriculum on 7/8/14 for new staff to include specific instruction on isolation procedures. External ice scoop holders were installed on the first and second floor ice machines on 7/14/14. Latches were installed on ice machines on 7/16/14 to limit access to employees only. Signage was added on 7/15/14 directing residents to ask staff for assistance in retrieving ice.		



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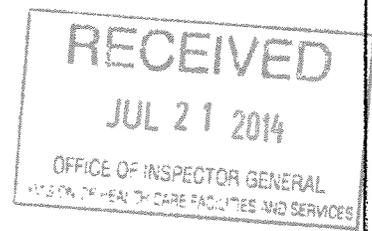
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F 441	<p>Continued From page 12</p> <p>#1 that Resident #1 was negative for C-Diff, but was to be treated as if he/she had C-Diff. RN #1 stated that CNA #1 did not inform her she was allergic to the isolation gowns. RN #1 stated this was something that she would need to know and hoped CNA #1 would of handled, knowing RN #1 had a couple of isolation patients. RN #1 stated she would have swapped CNA's to ensure the residents received proper care. RN #1 stated contact precautions meant that staff were wear gown and glove when in contact with the resident or bed, to ensure staff do not spread the infection onto their clothes or other residents.</p> <p>Interview with the Director of Nursing (DON), on 06/26/14 at 1:29 PM, revealed Resident #1 was placed on isolation prophylactically after Cipro (an antibiotic) was started. There was an order for Resident #1 to be on contact isolation from admission. Resident #1 had negative stool samples for Infections, but she was expecting the staff to follow the contact isolation precautions. The DON stated Resident #1 had been having diarrhea. The DON stated the process was for the staff to ask the nurse about the precautions and then don gown and gloves, take care of the resident, remove the soiled gown and gloves, then wash their hands before they exited the room. The DON stated she informed CNA #1 that if a resident had an infection or not that she was to wear the equipment. The DON stated if the resident was positive for C-Diff the aid could have transported the organism onto her clothes and other residents.</p> <p>2. Observation of CNA #3, on 06/24/14 at 3:15 PM, revealed CNA #3, passed ice and stopped at Resident #1's room. The CNA #3 then walked into Resident #1's room without donning gloves or</p>	F 441	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>ADON and weekend nurse supervisors will make 4 observations per week (on varying shifts) of staff entering rooms of residents with isolation precautions, for 1 month to ensure staff compliance. These observations will include 2 ice passes per week. Then the same individuals will make 2 staff observations per week for 2 months. Deficient practice will be addressed on the spot by the ADON/nurse supervisor with records of individuals counseled given to the DON. ADON will report results of observations to QA committee monthly for at least 3 months or until the committee is satisfied that systemic problems have been corrected. Food Service Director will check ice machines and ice chests to ensure that scoops are placed back in holders and latches on ice machines are secured when not in use. Checks will be performed 2 times per week for 1 month, then weekly for at least 2 months or until 100% compliance is achieved for 3 consecutive weeks. Consultant dietician will be asked to observe staff for hand hygiene in her monthly audits of food service.</p>		



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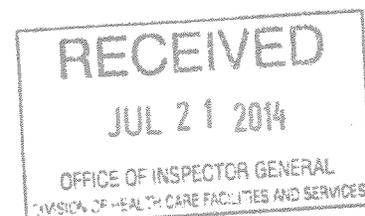
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F 441	<p>Continued From page 13</p> <p>gown. CNA #3 exited the room with Resident #1's water pitcher, and placed the water pitcher on the ice cart. CNA #3 then placed ice into the water pitcher and returned the water pitcher to Resident #1's room.</p> <p>Interview with CNA #3, on 06/26/14 at 3:02 PM, revealed she was not aware that she had taken Resident #1's water pitcher out of his/her room. CNA #3 stated she was aware Resident #1 was on contact precautions for C-Diff and was taught to bring another cup into the isolation room, but not out of the isolation room.</p> <p>Observation of CNA #2, on 06/24/14 at 3:15 PM, revealed while CNA #3 was passing ice, CNA #2 walked out of Resident #1's room with a Boost (nutritional drink), then walked to the communal refrigerator, and placed the Boost into the refrigerator.</p> <p>Interview with CNA #2, on 06/24/14 at 3:15 PM, revealed CNA #2 saw the family waving hello and walked into the doorway to say hello. CNA #2 stated she understood what was brought out of a residents room was considered dirty, and that she should have not placed the milk into the refrigerator. CNA #2 stated the Boost was not Resident #1's, but another residents. CNA #2 immediately removed the Boost from the refrigerator, and washed her hands.</p> <p>Interview with the DON, on 06/26/14 at 1:29 PM, revealed when staff passed ice to an isolation room, the staff were to gown and glove. The staff should not take equipment, such as an ice cart or ice scoop, nor take the water pitcher out of the isolation room. The DON stated when items were</p>	F 441	<p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>Reports of audits will be given to Food Service Director and Executive Director. ADON and Food Service Director will include reports of inadequate hand hygiene and checks on ice machines/chests in monthly QA reports until 100% compliance in this area is achieved for three consecutive months.</p>		



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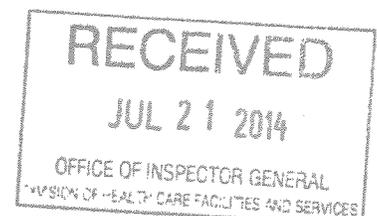
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F 441	<p>Continued From page 14</p> <p>taken out of a room the item was considered contaminated. The DON stated it did alarm her that the staff had broken contact isolation precautions. The DON stated the staff had been educated on contact precautions within the year.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/26/14 at 2:49 PM, revealed she had completed an in-service training on isolation precautions in May 2014, in which she educated the staff on isolation precautions and C-Diff precautions. The ADON stated the staff were educated to don gown and gloves when they entered the rooms. The ADON stated she had not talked to the staff about what to do when passing ice into a contact isolation room, but if she had witnessed it she would have educated the staff member on the spot. The ADON stated she monitored the staff frequently and did not document when the monitoring occurred. The ADON stated she expected the staff to use a Styrofoam cup when passing ice to a resident on contact isolation. The ADON stated staff should have thrown the Boost in the trash or gotten rid of it before they entered the resident room.</p> <p>Interview with the Medical Director, on 06/24/14 at 5:00 PM, revealed if Resident #1 was placed on contact isolation, the Resident should be treated as such. If the contact isolation sign says you need to wear gown and gloves, then the staff need to wear gowns and gloves. The Medical Director stated he was not sure if the resident was infectious or not. Infectious diarrhea means that they were not really sure if Resident #1 was infected or not. The Medical Director stated the issue was that Resident #1 was on isolation, even if it was utilized as a precaution.</p>	F 441		



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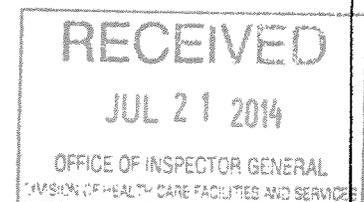
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F 441	<p>Continued From page 15</p> <p>3. Observation during the morning meal service, on 06/24/14 at 8:57 AM, revealed a Certified Nursing Assistant (CNA) was in Resident #1's room, sitting in a chair, feeding the resident. The CNA was observed to use the bed controls to adjust the head of the resident's bed, and without having performed hand hygiene proceed to feed the resident. A contact isolation sign was noted hanging on the door frame and a box of Personal Protective Equipment (PPE) was located just outside the room. The CNA was not wearing PPE or gloves.</p> <p>4. Observation of the morning meal, on 06/24/14 at 8:30 AM, revealed the ice machine had the scoop stored in the ice and not in the holder attached to the machine. Interview with CNA #4, on 06/26/14 at 1:45 PM, revealed the ice scoop should be stored in the holder attached to the machine to prevent cross contamination. The CNA revealed she was not aware the scoop was stored in the ice. Interview with the ADON, on 06/26/14 at 3:00 PM, revealed she was in charge of the infection control program. The ADON revealed they had identified a problem with proper storage of the scoop and had the Food and Nutrition Service Manager provide staff training on proper storage. The ADON revealed she was aware of one (1) resident who would use the ice machine and she had monitored the resident's use to ensure proper storage was done. The ADON revealed she randomly audited the ice machine and looked at scoop storage every time she was in the dining room. The ADON revealed a potential for the scoop and subsequently the ice to become dirty by improper scoop storage.</p> <p>4.) Observation, on 6/24/14 at 8:40 AM, during</p>	F 441			



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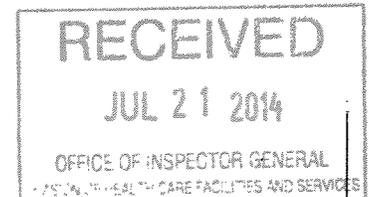
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F 441	Continued From page 16 the breakfast meal observation, revealed un-sampled Resident #A opened the ice machine and reached into the machine to retrieve the scoop. Un-sampled Resident #A placed his/her cup over the ice and scooped ice into his/her cup. After the cup was filled, the Resident placed the scoop in the scoop holder on the side of the machine, and closed the lid.	F 441	F 463 What corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were affected by the deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice:	
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 and interview, it was determined the facility failed to ensure four (4) of four (4) public restrooms were equipped with a functioning communication system. The findings include: The facility did not provide a policy on emergency call system. Observation, on 6/24/14 at 8:30 AM, during the initial tour, revealed three (3) public restrooms on the first floor and one (1) public restroom on the second floor were unlocked and accessible to residents. The four (4) restrooms were without a functioning communication system. Interview with the Maintenance Director, on 6/26/14 at 8:20 AM, revealed he did not realize	F 463	Residents who are independently mobile (ambulatory or mobile non-ambulatory) were at risk of entering the restrooms and not being able to communicate a need for assistance. Residents visiting with family or friends in the activity room were also at risk of being assisted by family/friends into the restroom and not being able to communicate a need for assistance. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Locks that remain locked until opened with a key were installed on 7/15/14 on the doors of the four restrooms identified during the survey. These locks are designed to remain locked at all times. Keys will remain in staff possession, with visitors directed by signage to see a staff member to access the restroom.	



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F 463	Continued From page 17 the four (4) restrooms needed communication systems. He stated that he knew the three (3) restrooms on the first floor were kept unlocked and all four (4) restrooms were for staff and visitors only. Interview with the Assistance Administer, on 6/26/14 at 9:00 AM, revealed she did not realize the three (3) restrooms on the first floor needed to have communication systems. She stated that the one (1) restroom on the second floor was suppose to be locked at all times.	F 463	How the facility plans to monitor its performance to ensure that solutions are sustained: Director of Environmental Services will round weekly for 1 month, then monthly thereafter, to ensure that public restrooms are being kept locked. Non-compliance with restroom locks will be reported to the QA committee monthly until complete compliance, based on observations by Director of Environmental Service, is achieved for 3 consecutive months.	7/15/14 7-16-14 PNCg by PB 7-21-14	



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a) 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 the First and Second Floors and two (2) in the Basement.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</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 Recertification Life Safety Code Survey was conducted on 06/24/14. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.