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

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185137	A. BUILDING B. WING OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES	C 07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER TERRACE	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 An abbreviated survey was initiated on 07/05/11 and concluded on 07/07/11 investigating KY# 00016649 and KY# 00016650. KY# 00016649 was substantiated and KY# 00016650 was unsubstantiated. Deficiencies were cited with the highest scope and severity of a D for KY# 00016649.	F 000	Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required under the provisions of federal and state law.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review of the facility's policy, the facility's investigation report, and interview, it was determined the facility failed to complete a thorough investigation as a result of a concern reported by the facility on 06/30/11 regarding a lab result was delayed in reporting to the Attending Physician for one (1) of four (4) sampled residents. A culture and sensitivity report for Resident #2 was reported by the lab to the facility on 06/21/11, but was not communicated/called to the Attending Physician. The Attending Physician found the culture and sensitivity report in the physician folder at the Nurse's station on 06/25/11, which resulted in a delay of antibiotic treatment for Resident #2. The findings include: Record review of the facility policy for Accidents	F 226	1. Upon discovery of the delay in the physician notification of the lab result the resident was assessed for signs and symptoms of UTI, the issue was discussed with the physician, antibiotic was ordered as prescribed and therapy was initiated. 2. Review of lab reports and subsequent new orders for all residents was completed. No other omissions were found. 3.Re-education of nursing staff was conducted on July 15 and 20 re: reporting and investigating accidents/incidents and suspected abuse. 4.A QA audit using the electronic charting system will be implemented August 1 to review all accidents/ incidents and suspected abuse for reporting and investigating per policy. The audit will be conducted by the ADON and submitted to the QA&A Committee for their review and recommendations. It will be continued or discontinued based on recommendations of the Committee.	8/6/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/29/11

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

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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 226	Continued From page 1 and Incidents-Investigating and Reporting revealed all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on the premises shall be investigated and reported to the Administrator. The Report of Incident/Accident form should include: the name(s) of witnesses and their accounts of the accident or incidents and other pertinent data as necessary or required. Record review of the investigation regarding Resident #2 dated 06/30/11, revealed a lab result (culture and sensitivity) was reported on 06/21/11, but not called to the Attending Physician. The facility investigation was completed by the Director of Nursing (DON), which included a written statement provided by RN #1, dated 06/28/11, a written statement which detailed the incident findings, signed by the DON, and a hand-written facility form: Resident Abuse Investigation Report Form. Interview, on 07/06/11 at 1:00 PM, with the attending physician revealed he was sure the facility staff did not contact him with the results of the culture and sensitivity report for Resident #2, dated 06/21/11. The Attending Physician did not know RN #1 was the staff member responsible for communicating the culture and sensitivity result, and was surprised to know that RN #1 had not called him promptly. Interview, on 07/07/11 at 3:00 PM, with LPN #2 revealed she was working on 06/25/11 when the Attending Physician was making rounds on the unit. LPN #2 stated the attending physician became angry when he reviewed his physician folder and found a culture and sensitivity report	F 226		

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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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F 226	Continued From page 2 for Resident #2, and he asked why he had not received notification when the results were reported on 06/21/11. LPN #2 stated that when she checked the Twenty-four (24) hour sheets, there was a note from 06/21/11 to call the Attending Physician with the results of the culture and sensitivity. LPN #2 stated she was not asked to provide a written statement with a detailed account of the incident. LPN #2 reported the incident to the DON. Interview, on 07/6/11 at 3:15 PM, with the DON revealed she was responsible for completing investigations and reporting to the appropriate agencies. The DON said she spoke directly with the Attending Physician and with LPN #2, but did not document the conversations or obtain a written statement regarding their accounts of the incident. The DON stated since RN #1 did not follow facility policy, she did not think it was necessary to include statements from witnesses of incident in the facility investigation. The DON stated the findings of the facility investigation were based on the fact that RN #1 did not follow facility policy. Interview, on 07/07/11 at 3:00 PM, with the Administrator revealed the DON completed the facility investigations of incident reports. The Administrator was told about the lab result for Resident #2 which was reported on 06/21/11, but not communicated to the Attending Physician until 06/25/11. The Administrator said she did not review the investigation completed by the DON, but was in agreement with the findings, and said RN #1 left unfinished business. The Administrator said she expects facility staff to follow-up as necessary to ensure good	F 226		

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WESTMINSTER TERRACE	2116 BUECHEL BANK ROAD LOUISVILLE, KY 40216

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F 226	Continued From page 3 communication. The Administrator was not aware that written statements from the Attending Physician or LPN #2 were not obtained during the investigation, but thought the interviews should have been included.	F 226		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, facility nursing and pharmacy policy review, and interview, it was determined the facility failed to provide pharmaceutical services to ensure accurate dispensing and administration of drugs to meet the needs of one (1) of four (4) sampled	F 425	1.When the duplicate order was discovered the physician was immediately notified, the order clarified, the resident was monitored every hour and an investigation into the matter was begun. 2.Residents e-MARs and MD orders were reviewed on 6/26 to check for duplicate orders. Both generic and brand names of meds are listed on the e-MAR with each medication (copy attached). 3.The administrator met with the general manager and consultant pharmacist from the pharmacy and discussed the pharmacy related areas of the SOD. The general manager stated that they have ongoing tracking/trending mechanisms in place that will identify such occurrences in the future. This occurrence was addressed with Pharmacist #1 by the pharmacy general manager on 7/26. A Reeducation of pharmacy staff was completed by the general manager on 7/26 re: the internal occurrence reporting process. There will be re-education of licensed nursing staff and CMTs re: reconciliation of orders, medication administration, the pharmacy policies, "Pharmacy Related Occurrence Reporting" and Medication Errors (copies attached).	8/6/11 ~~8/10/11~~ gmb

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STREET ADDRESS, CITY, STATE, ZIP CODE: 2116 BUECHEL BANK ROAD, LOUISVILLE, KY 40218

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F 425	Continued From page 4 residents, Resident #1. Resident #1 received a duplicated dose (dispensed by the pharmacy) of the antihypertensive drug, Diltiazem (trade name, Tiazac) (a drug to lower blood pressure) after re-admission to the facility. The findings include: Review of the facility's pharmacy policy titled "Resident Assessment/Reassessment" revised 01/10/06 revealed. . . the Pharmacy will perform an assessment for therapeutic appropriateness and contraindications on all medication orders for each resident upon admission and with each new medication order. The policy revealed the drug order assessments may only be conducted by a pharmacist who has completed the orientation process and has received an initial competency assessment, or, if this has not occurred, the pharmacist performing these functions must be under the supervision of an assigned preceptor. The policy also revealed the reviewing pharmacist will minimally review all current diagnoses and all current medications to determine if there are opportunities for patient specific therapeutic interchanges, or if there are potential significant medication interactions, therapy duplications, disease state contraindications, or other medication related clinical issues pertinent to the patient. In addition, the pharmacy policy revealed . . .any finding requiring immediate intervention will be the responsibility of the internal clinical pharmacist (e.g. a significant drug interaction, a patient allergy, a disease state contraindication, an abnormal laboratory value contraindication, etc.) to resolve before dispensing is authorized and the clinical pharmacists' assessment takes place immediately and prior to dispensing the	F 425	Orders for all residents who are new admissions or readmissions are reviewed by two licensed nurses at the morning clinical meeting. (Clinical Meeting Process-24 Hour Follow-Up copies attached). The DON, ADON, clinical managers, staff development and MDS coordinators will be trained by the Consulting Pharmacist on August 1 and 2 re: how to conduct Med Pass Observations. MedPass observations will be completed for all newly hired licensed nurses and CMTs at the completion of their introductory period of employment and annually as a competency test for their performance evaluation. 4. QA audits will be initiated on August 1 as follows: Accurate transcription of orders, (audit form attached) will be completed by the 11-7 nurse on each unit each day for all new orders. MedPass observations (form attached), 5 will be completed quarterly by one of the previously trained nurse managers. The administrator will review (form attached) 5 randomly selected accident/incident reports and all medication error reports each month to assure that a thorough investigation was conducted. Findings of all QA audits will be presented and discussed at the monthly QA&A Committee meeting. These audits will continue until the Committee recommends a change.	

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F 425	Continued From page 5 medication. Review of the facility's nursing policy "Admission Notes" (undated) revealed the admission nurse was to: 1. When a resident is admitted to the nursing unit, the Charge Nurse must record the following data (as each may apply) in the nurses' notes or other appropriate place, as designated by nursing policy; h. The time the physician's orders were received and verified;. Review of the facility nursing "ADMISSION CHECK LIST" revealed the admitting nurse was to review discharge orders received from another facility, verify those orders with the facility attending physician, and fax a copy of those medication orders to the pharmacy. Review of the facility's investigation of the incident regarding the duplication of a medication dose for Resident #1, revealed the facility found the admitting nurse to have made a physician's order transcription error in regards to duplication of the drug Diltiazem. The duplicated order was sent to the pharmacy, the pharmacy did not discover the transcription error, the duplicated medication dosage was dispensed, and a nurse administered one (1) dose of the duplicated medication. Record review for Resident #1 revealed the facility had assessed Resident #1 as being interviewable per the Minimum Data Set dated 06/14/11, but the resident was out of the facility during survey having been admitted to the acute care hospital for an unrelated medical condition. Resident #1 had been admitted to the acute care hospital on 06/20/11 with the diagnosis of Symptomatic Hypotension. Resident #1 had other diagnoses to include Congestive Heart	F 425		

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2110 BURCHEL BANK ROAD LOUISVILLE, KY 40218	

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F 425	Continued From page 6 Failure, Ischemic Cardiomyopathy, and Diabetes Mellitus. The facility re-admitted the resident to the facility on 06/23/11 from an acute care hospital. Interview with the RN Unit Manager, who admitted Resident #1 to the facility from an acute care hospital, on 07/06/11 at 1:55 PM, revealed she had received discharge medication orders from the hospital for Resident #1 on 06/23/11 which included a discontinued dosage of Diltiazem, but she transcribed this dosage onto the new medication orders. She stated she asked the attending physician if he wanted Resident #1 to have medication orders continued from the resident's last admission to the facility plus to add the additional medications ordered by the discharging physician, and she wrote an order that he did request this. She continued the previous orders for Resident #1 in addition to the new medication orders and did not see the duplicated order for Diltiazem. Interview, on 07/06/11 at 2:15 PM, with the Director of Nursing (DON), who did the facility investigation, revealed the Pharmacy was not informed of the medication error when it was discovered, and had not been informed of the error. The DON stated she probably should have informed the Pharmacy due to their involvement in the medication error. The DON also stated it was the facility practice to call the pharmacy if it was suspected the pharmacy had made a medication related error i.e. duplication of medication, dispensing error, etc., but she had no reason why it had not been done regarding this error.	F 425		

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F 425	Continued From page 7 Interview with Pharmacist #1, on 07/07/11 at 1:15 PM, revealed she was the pharmacist who reviewed the set of medication orders for Resident #1 which contained the duplication order for Diltiazem. She stated she missed the duplication order. She stated she had probably been distracted possibly up to eight (8) times during her review of this medication order profile as this occurred frequently at the pharmacy. She also stated she would 'normally' have caught such a duplication order. Pharmacist #1 stated the computer database system in the pharmacy has an alert system built into it to warn pharmacists' doing the reviews if there is a duplicated order, drug interaction concern, disease contraindication, etc.. However, she stated it is possible for the pharmacists' to become de-sensitized to these alerts. Pharmacist #1 stated she would have contacted the facility nurse to get a clarification order from the physician to discontinue one dose of the Diltiazem if she had recognized the duplication. Interview with the facility consulting pharmacist, Pharmacist #2, on 07/06/11 at 10:00 AM, revealed he was unaware of the medication error for Resident #1. He also stated the outcome of the duplication of 180mg. of Diltiazem (drug to prevent high blood pressure) could be that the resident's blood pressure would drop too low approximately eleven (11) to twelve (12) hours after the added dose. Record review for Resident #1's blood pressure monitoring revealed this did not occur. Interview with the Pharmacy Manager, on 07/07/11 at 9:30 AM, revealed he did not collaborate with the facility leadership and staff,			

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F 425	Continued From page 8 but he had a consultant pharmacist who was the liaison at the facility. He stated the facility did not share nursing medication errors with the pharmacy but he thought it would be beneficial for the facility to do so. The Pharmacy Manager stated he had a system in place to review the pharmacist reviewers for quality assurance and did this when a problem arose, but he did no routine monitoring of the pharmacists' who were assessing medication orders. Interview with the Administrator, on 07/07/11 at 2:15 PM, revealed she was unaware the pharmacy had not been notified of the medication error for Resident #1, but stated they should have been notified. The Administrator revealed nursing medication errors are not required to be submitted to the Quality Assurance (QA) Committee for review, and they are not tracked or trended, but they probably should be. She stated the consultant pharmacist, Pharmacist #2, attended the facility QA Committee meetings, but he was not made aware of the facility nursing medication errors during that meeting, and had not been made aware of the dispensing and administration error regarding Resident #1.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	1.No residents were affected by this practice. 2.The MRR had been done monthly by the consulting pharmacist (CP) on an ongoing basis and the report given to the DON. No residents had been adversely affected by this practice.	8/4/11

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F 428	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review, facility nursing and pharmacy policy review, review of Physician Orders, and interview, it was determined the facility failed to ensure a drug regimen review for one (1) of four (4) sampled residents was completed monthly by a licensed pharmacist. Documentation of drug regimen reviews by a licensed pharmacist since October, 2011 were not signed as reviewed on a monthly basis for Resident #2. The findings include: Review of Omnicare, Inc. policy for Long Term Care Facilities Receiving Services from Pharmacy, dated December, 2008, revealed the consultant pharmacist will conduct medication regimen reviews (MMR) in accordance with applicable law. The copies of MMRs remain on file in the Facility, either as part of the resident's permanent medical record or in a special file. Review of Physician Orders for Resident #2 revealed during the months of October, 2010, and January and March, 2011, the licensed pharmacist did not document the MMR as completed by signature and date on the Physician Orders. The Physician Orders dated November,2010, were signed by a licensed pharmacist and dated as 12/03/10 on page 1, and signed and dated as completed on 11/03/10 on page 3 of the Physician Orders. The Physician Orders dated December, 2010 were signed by a	F 428	3.A form, Medication Regimen Review (copy attached) will be implemented August 1, 2011. Each month the CP will complete a review of each resident's medication and will use this form to summarize his findings, sign and date the form then place it behind the Pharmacy tab in the resident's medical record. Appropriate nursing staff will receive inservice and physicians will be notified via letter (copy attached) re: this policy and the form. 4.A QA audit consisting of 25% of the total medical records will be completed by the ADON monthly to assure forms have been completed and placed appropriately in the medical record. The findings will be submitted to the QA&A Committee and continue until there is a recommendation for change from the Committee. AMENDED POC 1.When the duplicate order was discovered the physician was immediately notified, the order clarified, the resident was monitored every hour and an investigation into the matter was begun. 2.Residents e-MARs and MD orders were reviewed on 6/26 to check for duplicate orders. Both generic and brand names of meds are listed on the e-MAR with each medication (copy attached).	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OR8Q11 Facility ID: 100242 If continuation sheet Page 10 of 23

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Medication Administration Record

(Administration Record)

Westminster Terrace Healthcare Centre
For the month of: *June 2011*

Description	Time Codes	1 W	2 T	3 F	4 S	5 S	6 M	7 T	8 W	9 T	10 F	11 S	12 S	13 M	14 T	15 W	16 T	17 F	18 S	19 S	20 M	21 T	22 W	23 T	24 F	25 S	26 S	27 M	28 T	29 W	30 T	31
ANOXIN 0.125 mg give 1 tab daily tart Date: 6/02/11 iscontinue Date: 6/04/11 IGOXIN 27.31 Atrial Fibrillation	8:30 AM	*	*	✓ OH	✓ EL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
ASIX 40 MG TABLET, give one tab orally every day tart Date: 6/02/11 Iscontinue Date: 6/04/11 UROSEMIDE 28.0 Chf Nos	8:30 AM	*	*	✓ OH	✓ EL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
YZAAR 100-25 TABLET give one tab orally daily tart Date: 6/02/11 Iscontinue Date: 6/04/11 OSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE 01.9 Hypertension Nos	8:30 AM	*	*	✓ OH	✓ EL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
SPIRIN EC 81 MG TABLET give 1 tab orally every ay tart Date: 6/07/11 Iscontinue Date: 6/20/11 SPIRIN 27.31 Atrial Fibrillation	8:30 AM	*	*	*	*	*	*	*	✓ OH	✓ OH	✓ OH	✓ EL	✓ EL	✓ KC	✓ KC	✓ OH	✓ OH	✓ OH	✓ EL	✓ EL	✓ EB	*	*	*	*	*	*	*	*	*	*	*
ARTIA XT 180 MG CAPSULE tart Date: 6/07/11 Iscontinue Date: 6/20/11 ILTIAZEM HCL 01.9 Hypertension Nos	8:30 AM	*	*	*	*	*	*	*	✓ OH	✓ OH	✓ OH	✓ EL	✓ EL	✓ KC	✓ KC	✓ OH	✓ OH	✓ OH	✓ EL	✓ EL	✓ EB	*	*	*	*	*	*	*	*	*	*	*

Signature	Init.	Signature	Init.	Signature	Init.	Signature	Init.

Advanced Directives	Diet	Resident Preference for MAR/TAR
ULL CODE	Healthy heart/NCS	WHOLE
x: 719.7 Difficulty In Walking	V15.88 PERSONAL HISTORY OF FALL	784.60 Symbolic Dysfunction Nos
784.7 Epistaxis	728.87 MUSCLE WEAKNESS-GENERAL	802.0 Nasal Bone Fx-Closed
599.71 GROSS HEMATURIA	781.2 Abnormality Of Gait	959.4 Hand Injury Nos

llergies: NKDA

hysician: *Alt. Phys:* *Ht:* *Wt:*

hys. Ph: *Alt. Phys. Ph:* *M/R No.:*

Resident Name	Res No.	Unit Room Bed	D.O.B.	Sex	Admit Date
		00			

PRESBYTERIAN HOMES O
5024993596
02:15
08/04/2011

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

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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 C 07/07/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2115 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 428	Continued From page 10 licensed pharmacist and dated as 01/05/11 on page 2, and signed and dated as completed on 02/03/11 on page 3 of the Physician Orders. The Physician Orders dated February, 2011 were signed by a licensed pharmacist and dated as 04/05/11 on page 2, and signed and dated as completed on 03/02/11 on page 3 of the Physician Orders. The Physician Orders dated April, 2011 were signed by a licensed pharmacist and dated as completed on 05/04/11. Interview with the facility consulting pharmacist, Pharmacist #2, on 07/07/11 at 1:35 PM, revealed MMR are completed on a monthly basis for each resident. Pharmacist #2 stated the most current set of Physician Orders is reviewed monthly for each resident, and the pharmacist then signs and dates the page of the Physician Orders where the Physician signed, because that sheet is less likely to be removed from the chart when thinned. Pharmacist #2 said the MMRs were completed for October, 2010, and January and March, 2010 even though the Physician Orders for those months were unsigned by a licensed pharmacist, and said the signatures appeared on subsequent months. Pharmacist #2 said the missing licensed pharmacist signature did not indicate the MMR was not completed during the month, but was not able to explain how to prove the MMR had been completed without the signature of the licensed pharmacist on each monthly set of Physician Orders. Pharmacist #2 stated in the past, the MMR was designated as completed with a pharmacist signature and date on a separate page kept within the resident record and suggested the prior process might be a better way to ensure MMRs are completed timely and on a monthly basis.	F 428		

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F 428	Continued From page 11	F 428		
	Interview with the Administrator, on 07/07/11 at 3:00 PM, revealed the facility expects the MMRs to be completed on each resident on a monthly basis, and stated the consulting pharmacist should document the MMR as completed with a signature and date on each set of monthly Physician Orders. The Administrator was not aware of the inconsistent documentation of MMR with regard to the resident record of Resident #2, and acknowledged the current practice of documentation could lead to confusion. The Administrator stated she intends to discuss the current practice with the consulting pharmacy service and identify the best practice to ensure compliance with the monthly MMRs.			8/6/11
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		
	A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.		1.When the duplicate order was discovered the physician was immediately notified, the order clarified, the resident was monitored every hour and an investigation into the matter was begun.	
	This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to be administered in a manner to ensure the integrated delivery of care and services to attain or maintain the highest practical well-being of each resident.		2.Residents e-MARs and MD orders were reviewed on 6/26 to check for duplicate orders. Both generic and brand names of meds are listed on the e-MAR with each medication (copy attached).	
	The findings include:		3.The administrator met with the general manager and consultant pharmacist from the pharmacy and discussed the pharmacy related areas of the SOD. The general	
	Record review for Resident #1 revealed the facility re-admitted the resident on 06/23/11.			

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F 490	Continued From page 12 Resident #1 received a duplicated dose of Diltiazem (an antihypertensive drug) on 06/24/11 at 8:30am but did not have a drop in blood pressure due to this duplicated dose. Review of the facility's investigation of the incident revealed Resident #1 had received a duplicated dose of Diltiazem (an antihypertensive drug) on 06/24/11, and the facility found the admitting nurse made a physician's order transcription error in regards duplication of the drug Diltiazem. Interview with the facility consulting pharmacist, Pharmacist #2, on 07/06/11 at 10:00 AM, revealed he was unaware of the medication error for Resident #1. Pharmacist #2 indicated he or the pharmacy would be made aware of a potential pharmacy medication error by a phone call from one of the nursing staff. Interview with Pharmacist #1, on 07/07/11 at 1:15 PM, revealed she was the pharmacist who reviewed the set of medication orders for Resident #1 which contained the duplication order for Diltiazem. She stated she missed the duplication order. Pharmacist #1 stated she would have contacted the facility nurse to clarify the order from the physician. Interview with the Pharmacy Manager, on 07/07/11 at 9:30 AM, revealed he did not collaborate with the facility leadership and staff, but the consultant pharmacist was the liaison at the facility. He stated the facility did not share nursing medication errors with the pharmacy, but he thought it would be beneficial for the facility to do so.	F 490	manager stated that they have ongoing tracking/trending mechanisms in place that will identify such occurrences in the future. This occurrence was addressed with Pharmacist #1 by the pharmacy general manager on 7/26. A Reeducation of pharmacy staff was completed by the general manager on 7/26 re: the internal occurrence reporting process. There will be re-education of licensed nursing staff and CMTs re: reconciliation of orders, medication administration, the pharmacy policies, "Pharmacy Related Occurrence Reporting" and Medication Errors (copies attached). Orders for all residents who are new admissions or readmissions are reviewed by two licensed nurses at the morning clinical meeting. (Clinical Meeting Process-24 Hour Follow-Up copies attached). The DON, ADON, clinical managers, staff development and MDS coordinators will be trained by the Consulting Pharmacist on August 1 and 2 re: how to conduct Med Pass Observations. MedPass observations will be completed for all newly hired licensed nurses and CMTs at the completion of their introductory period of employment and annually as a competency test for their performance evaluation. 4. QA audits will be initiated on August 1 as follows:	

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F 490	Continued From page 13 Interview with the DON, on 07/08/11 at 2:15 PM, revealed she had completed the investigation regarding the duplication of a dosage of Diltiazem for Resident #1. She stated she did not inform the pharmacy of the medication administration error and the pharmacy dispensing error. She indicated she knew she should have reported the error to the pharmacy. Interview with the Administrator, on 07/07/11 at 2:15 PM, revealed she was unaware the pharmacy had not been notified of the medication error for Resident #1, but stated they should have been notified. The facility nursing medication errors and the pharmacy medication errors were not monitored or analyzed by the facility.	F 490	Accurate transcription of orders, (audit form attached) will be completed by the 11-7 nurse on each unit each day for all new orders. MedPass observations (form attached), 5 will be completed quarterly by one of the previously trained nurse managers. The administrator will review (form attached) 5 randomly selected accident/incident reports and all medication error reports each month to assure that a thorough investigation was conducted. Findings of all QA audits will be presented and discussed at the monthly QA&A Committee meeting. These audits will continue until the Committee recommends a change.	8/6/11
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review, facility nursing policy review, review of lab results, review of Nursing Progress Notes, review of Physician Orders, and interview, it was determined the facility failed to ensure the physician was notified of lab results in a timely manner for one (1) of four (4) sampled residents. The lab reported a culture and sensitivity to the facility on 06/21/11, it was not reported to the attending physician which delayed antibiotic treatment of a urinary tract infection for Resident #2. The findings include:	F 505	1.Upon discovery of the delay in the physician notification of the lab result the resident was assessed for signs and symptoms of UTI, the issue was discussed with the physician, antibiotic was ordered as prescribed and therapy was initiated. 2.Review of lab reports and subsequent new orders for residents was completed. No other omissions were found. 3.Re-education of licensed nursing staff (refer to attached information) re: Lab and Diagnostic Test Results – Clinical Protocol and Guidelines for Notifying Physicians of Clinical Problems policies (copies attached) was conducted on July 11 and 12 with emphasis on timely notification and appropriate follow-up. A new 24 hour report system (copy of process attached) was implemented	8/10/11

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F 505	Continued From page 14 Review of the facility policy: Lab and Diagnostic Test Results-Clinical Protocol dated August, 2009 revealed when the physician had requested to be notified as soon as a result is received the staff should notify the physician by phone, fax, voicemail, e-mail, pager, or a telephone message to another person acting as the physician's agent on an immediate basis. This policy further states, if the attending physician does not respond to immediate notification within an hour, the nursing staff should contact the Medical Director for assistance. Record review of a faxed lab report for Resident #2, dated 06/19/11 at 2:47 AM, revealed a urinalysis result with abnormal findings as positive for nitrates (indication of urinary tract infection). Record review of Nursing Progress Notes, dated 06/19/11 at 6:56 AM, for Resident #2 revealed the night shift RN received a urinalysis result with a positive nitrate level, and documented in the Nursing Progress Notes that the physician would be contacted with the result in the morning. Review of Nursing Progress Notes, dated 06/19/11 through 06/25/11, did not reveal documentation of any attempts to contact the Attending Physician with the urinalysis results. Record review of the urine culture result, dated 06/21/11 at 8:30 AM, for Resident #2 did not include documentation on the report to indicate the result was communicated to the Attending Physician. The Attending Physician documented on the report that the result was reviewed by him on 06/25/11.	F 505	on July 25 to enhance communication and proper follow up. 4.An audit (copy of form attached) of timely notification to physician of all lab results will be conducted weekly by the unit secretary and submitted to the Quality Assessment and Assurance (QA&A) Committee monthly. The audit will be continued or discontinued based on recommendations from the Committee. Any negative findings will immediately be brought to the attention of the DON who will address them with appropriate staff.	

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F 505	Continued From page 15 Record review of Nursing Progress Notes, dated 06/22/11 at 9:40 AM, for Resident #2 revealed a note by the Director of Nursing (DON) which detailed, "Dr. notified results of urine C&S: UTI. Notifications done. Follow-up ongoing." Record review of Physician Orders, dated 06/25/11, revealed an order for Cipro 250mg (antibiotic) twice daily by mouth for UTI (urinary tract infection) for a course of ten (10) days. Interview by telephone, on 07/06/11 at 1:00 PM, with the resident's physician revealed facility staff had been provided with a personal cell phone number to access the attending physician. The attending physician stated he requested the urinalysis for Resident #2, based on the positive nitrate finding and received a timely response with a result. Subsequently, the attending physician ordered a culture and sensitivity and asked for the results to be reported to him as Resident #2 would require treatment with an antibiotic. The attending physician said when he rounded at the facility on 06/25/11, he found the culture and sensitivity report in his folder at the Nurse's Station which was dated 06/21/11. The attending physician stated the facility procedure for physician notification includes documentation by a nurse on the lab result form, which would indicate the results were called to the physician and the documentation should include any orders obtained. The culture and sensitivity report for Resident #2 dated 06/21/11 had no documentation by the nursing staff. The attending physician said it was not clear to him if any nursing staff member had reviewed the report. The attending physician said the delay in reporting of the culture and sensitivity to him,	F 505		

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F 505	Continued From page 16 resulted in a four (4) day delay to initiate antibiotic therapy for Resident #2 to treat the UTI. The attending physician stated this was unacceptable and complained of the failure to report lab results in a timely manner, but was unsure with whom he spoke about the failure to report the lab result for Resident #2. Interview by telephone, on 07/06/11 at 2:00 PM, with RN #1 revealed she attempted to notify the attending physician of the culture and sensitivity results for Resident #2 on 06/21/11. RN #1 stated she called the cell phone number and the call was disconnected during the conversation with the attending physician. RN #1 stated she attempted to return the call, but reached the voicemail only, and was not able to speak with the attending physician after several attempts. RN #1 stated she called the office number and was told the attending physician was in meetings all day, and left a message requesting a call back. RN #1 did not know who she spoke with at the attending physician's office. RN #1 said the attending physician did not call back on 06/21/11 by the time her shift ended, so she verbally reported to the next shift that the culture and sensitivity for Resident #2 needed to be reported to the attending physician. RN #1 said she documented the need to report the finding on the Twenty-four (24) hour report and on the lab report sheet, and placed the report in the attending physician's folder at the Nurse's Station. RN #1 did not think it was necessary to document her attempts to call the attending physician or obtain the name of the person at the attending physician's office with whom she spoke, because she verbally reported the need to communicate the culture and sensitivity to the attending	F 505		

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F 505	Continued From page 17 physician to the oncoming shift. RN #1 did not think it was necessary to contact the Medical Director to report the difficulty in reaching the attending physician as the facility policy stated, because the actions she had taken during her shift were sufficient to ensure the culture and sensitivity report for Resident #2 was reported to the attending physician. Interview, on 07/06/11 at 1:26 PM, with Staffing Coordinator #1 (34 years of service), revealed she has not experienced any difficulty reaching the attending physician by phone, and said she has the personal cell phone which is the easiest way to contact him. Staffing Coordinator #1 stated she was trained that all lab results are given immediately to the nurse and are to be communicated to the attending physician immediately. Interview, on 07/06/11 at 1:35 PM, with RN #2 revealed she was trained to immediately report lab results to the attending physician or Nurse Practitioner, and if unable to reach them it would be acceptable to leave a message with the Physician's office and request a call back. RN #2 stated all attempts for physician contact and physician orders should be documented in the Nursing Progress Notes, and stated if she was unable to reach the attending physician, after several attempts, she would call the Medical Director for assistance. RN #2 was trained to document the call to the attending physician, including date and time, any new orders, and sign the note on the lab report sheet. RN #2 said after the lab is reported to the Physician, it should be placed in the Physician's folder at the Nurse's Station and is reviewed and signed by the	F 505		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185137		C 07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER TERRACE	2118 BUSCHEL 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 505	Continued From page 18 attending physician when they round, and then placed on the resident record. Interview, on 07/06/11 at 3:15 PM, with the DON revealed during the Daily Clinical Meeting on 06/22/11, she reviewed a urinalysis and culture and sensitivity for Resident #2, and she asked RN #1 if these had been reported to the attending physician and was told by RN #1 that physician notification was completed. The DON said she documented in the Nursing Progress Notes that the results were reported to the attending physician based upon the response of RN #1. The DON stated that the attending physician complained to her on 06/26/11 when he found the lab result in his folder without any documentation that the lab result had been reported. The DON said RN #1 was responsible to report the result on 06/21/11 to the attending physician and stated this responsibility should not have been passed on to the next shift. The DON stated no documentation of efforts to reach the attending physician by RN #1 were found. The DON stated that RN #1 should have documented the calls in the Nursing Progress Notes, and on the lab result sheet. The DON did not know why RN #1 told her on 06/22/11 the lab results for Resident #2 were reported to the attending physician unless RN #1 assumed it had been done since she delegated the responsibility for physician notification to the next shift. Interview, on 07/07/11 at 3:00 PM, with the Administrator revealed a problem existed with communication of lab results to the Attending Physician regarding Resident #2. The Administrator stated RN #1 left unfinished business when she delegated the responsibility of	F 505		

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F 505	Continued From page 19 physician notification for lab results regarding Resident #2 to the next shift. The Administrator stated it is expected that staff follow through with all assigned responsibilities, and RN #1 should have reported the concern to her supervisor when she was unable to reach the Attending Physician. The Administrator could not verify what efforts RN #1 had made to contact the Attending Physician on 06/21/11 due to no documentation of the attempts made by RN #1 were found in the Nursing Progress Notes. The Administrator stated it was appropriate to document all physician contacts and attempts at physician contact in the Nursing Progress Notes.	F 505		8/6/11
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	1.Resident #1 had no adverse reactions as result of this med error. When the error was discovered the physician was immediately notified, the order clarified, the resident was monitored every hour and an investigation began. 2.All residents e-MARS were reviewed to check for duplicate orders. 3.Education re: facility med error and pharmacy related med error policies was provided for licensed nursing staff and CMTs. This included the requirement to record all med errors on the appropriate form in the electronic charting system thus allowing med errors to be tracked and trended. The electronic med error log is monitored prior to the clinical meeting by the DON who will address each one promptly with the appropriate staff member. Nurses and CMTs who administer	8/10/11

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F 520	Continued From page 20 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to monitor and analyze pharmacy and nursing medication error data to identify concerns with the quality of facility systems, in the Quality Assurance (QA) Committee. The findings include: Record review for Resident #1 revealed the resident was re-admitted to the facility on 06/23/11. Resident #1 received a duplicated dose of Diltiazem (an antihypertensive drug) on 06/24/11 at 8:30am but did not have a drop in blood pressure due to this duplicated dose. . Review of the facility investigation of the incident revealed Resident #1 had received a duplicated dose of Diltiazem (an antihypertensive drug) on 06/24/11, and the facility found the admitting nurse made a physician's order transcription error in regards duplication of the drug Diltiazem. The duplicated order was sent to the pharmacy, the pharmacy did not discover the transcription error, the duplicated medication dosage was dispensed, and a nurse administered one (1) dose of the duplicated medication. Record review for Resident #1's blood pressure monitoring revealed this did not occur. Interview with the facility consulting pharmacist,	F 520	medications will check each med on the e-MAR for possible duplications as part of the administration process. Any errors (duplications) found will be reported to the DON immediately who will notify the physician for order clarification and begin an investigation. 4.Nursing medication errors will be tracked/trended through the electronic charting system and reported to the QA&A Committee monthly by the DON. Any pharmacy med errors found during the month will be discussed at the QA &A Committee. These audits will be ongoing.	

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F 520	Continued From page 21 Pharmacist #2, on 07/06/11 at 10:00 AM, revealed he was unaware of the medication error for Resident #1. He stated he was not made aware of nursing medication errors in the facility QA Committee or by any other reporting system. Pharmacist #2 indicated he or the pharmacy would be made aware of a potential pharmacy medication error by a phone call from one of the nursing staff, and this information was used to track and trend pharmacy errors. He stated this information would go to the pharmacy QA Committee. He also stated he turned in a quarterly pharmacy report to the Administrator but this report data was not monitored or analyzed in the facility QA Committee. Interview with the Pharmacy Manager, on 07/07/11 at 9:30 AM, revealed he did not collaborate with the facility leadership and staff, but the consultant pharmacist was the liaison at the facility. He stated the facility did not share nursing medication errors with the pharmacy, but he thought it would be beneficial for the facility to do so. The Pharmacy Manager stated he had a system in place to review the pharmacist reviewers for quality assurance when a problem arose, but he did no routine monitoring of the pharmacists' who were assessing medication orders. The Pharmacy Manager also stated these reviews were not part of a quarterly pharmacy report made to the facility Administrator. Interview with the DON, on 07/06/11 at 2:15 PM, revealed she had completed the investigation regarding the duplication of a dosage of Diltiazem for Resident #1. She did not inform the pharmacy of the medication administration error and the	F 520		

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F 520	Continued From page 22 pharmacy dispensing error. She indicated she knew she should have reported the error to the pharmacy. The DON stated nursing medication errors were not reported at the QA Committee, but they would be reported in the future for tracking and trending, and identification of concerns. Interview with the Administrator, on 07/07/11 at 2:15pm, revealed she was unaware the pharmacy had not been notified of the medication error for Resident #1, but stated they should have been notified. The Administrator revealed nursing medication errors were not submitted to the QA Committee for review, and they were not tracked or trended, but they should be. She stated the consultant pharmacist, Pharmacist #2, attended the facility QA Committee but the facility nursing medication errors and the pharmacy medication errors were not monitored or analyzed there.	F 520		

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