

AMENDED POC (2)

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2. The resident's care plans state that staff will administer medications according to physician's orders and observe the resident for adverse side effects, document and report to physician. All med error reports were reviewed dates 10/17/11 through 10/29/11, there were no adverse side effects.

3. The policy, "Change in a Resident's Condition/Notification of Change" has been revised twice by the administrator, DON and ADON with input and final approval by the medical director on 12.5.11. The first revision was completed in October 2011 and implemented on October 26 with the purpose of providing direction for staff of action they are to take if there is no response or untimely response from the attending physician. The policy directs them to contact the DON if the attending physician has not returned their call in one hour. The DON, in turn, will contact the medical director. He advised that if it is necessary to call him, he will resolve the issue at hand and also contact the attending physician re: his/her noncompliance and the need to correct it. The policy also includes detailed information regarding staff responsibility to monitor the resident and document the vital signs and significant findings. The second revision was made by the administrator, discussed with the DON and ADON with final approval by the medical director. This was completed on 12.5.11 and the purpose of this revision was to clarify the difference between the need for "immediate" versus "within 24 hour contact" with the physician and responsible party. The first revision was addressed at mandatory inservices provided by the administrator and staff development coordinator for nurses on 10/23 and

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10/24/11. Those who were unable to be present received the same information via telephone with the presenter and a witness in the office. Those persons have since signed the attendance rosters to further document their attendance. All nurses received inservice re: the second policy revisions at mandatory programs conducted by the DON on December 7 and 8 and was implemented on December 9. Attendance of 100% was achieved for both inservice programs. The revised policy was initiated on December 9. These policies will receive increased emphasis during new employee orientation for all nurses. The policy, "Identifying and Managing Medication Errors and Adverse Consequences" was also revised by the administrator, DON and ADON with final approval by the medical director in October 2011 with implementation on October 26. These changes direct staff to report medication errors with potential adverse consequences to the attending physician immediately. As in the previous policy the DON will be contacted and likewise contact the medical director if the attending physician does not respond in an hour. The medical director has advised that he will resolve the issue and also contact the attending physician re: his/her noncompliance. The policies, "Care Plan" and "Care Plan-Comprehensive" were revised on 12/12 by the home office MDS Coordinator to include "evaluations" as they relate to care plans for residents requiring specialized rehabilitation and changing the word "RAP" to "CAA" to be consistent with current language. Changes were discussed and approved by the administrator prior to the change. A care plan inservice was provided by the home office MDS Coordinator on 12/7 and 12/8 for all

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nurses and the revised policies were implemented on 12/9.

4. Med Pass Observations using a tool presented by Omnicare Long Term Care Pharmacy through their consultant and approved by QA&A is used to conduct observations with all newly hired nurses and CMTs during their orientation process and with every nurse and CMT as part of their annual evaluation. Six randomly selected nurses or CMTs will also be observed each quarter by the consultant pharmacist and ADON/SDC. (the ADON/SDC were trained by the consultant pharmacist re: use of these tools.) A dosage calculation test developed by the DON and approved by the pharmacist and medical director will be used at these same times. This audit will provide education to the staff as well as identify their performance level. They must achieve 100% in both areas in order to administer medications. Results will be reported monthly to QA&A for their review and recommendations. The administrator will review the results of each as they are completed. This process was implemented in November 2011.

The audit, "Notification of Change" was developed by the administrator and discussed with the DON who was advised to monitor calls made to physicians and responsible parties re: changes in resident situations to determine that this was done in a timely manner. She will randomly select 5 residents where notification was required per unit weekly to determine if staff has made appropriate notifications. This was implemented on December 12. Weekly findings will be shared with the administrator by the DON and monthly findings will be submitted to QA&A beginning January 2012 for their review and recommendations.

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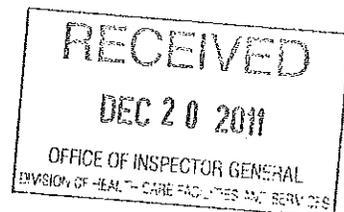
Effective November 1 the occurrence of medication errors is being monitored Monday through Friday by the ADON using a form developed by the home office MDS Coordinator and approved by QA&A. The administrator discussed the use of the form with the ADON.

The Medical Director and administrator will review the findings weekly for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations.

The Care Plan audit tool was revised by the home office MDS Coordinator to include more detailed information related to new orders as opposed to only completed timely/current care plans. This will be completed monthly by the in house MDS Coordinator, who was trained by the home office MDS Coordinator, for 20 randomly selected care plans. Negative findings will be addressed by the DON using the corrective action policy. The administrator will review one care plan weekly to assure compliance in terms of care. Overall findings will be submitted to the QA&A committee for their review and recommendations beginning at their January 18, 2012 meeting.

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12/19/11
date changed to
12-13-11 per
Jan Shoop
by PB 12-21-11



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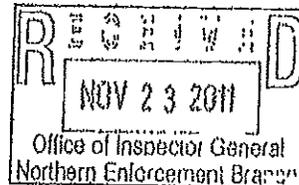
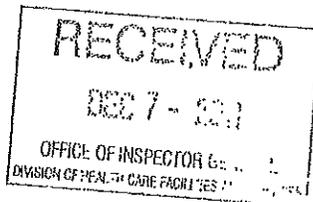
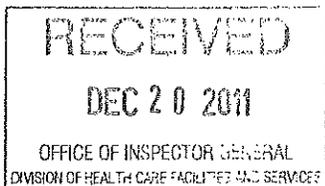
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2011	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 42 information regarding staff responsibility to monitor the resident and to document the vital signs and significant findings. The facility provided documentation of 100% compliance with staff education to the policy change; staff training began on 10/22/11 and concluded on 10/26/11. 5. Interview of three (3) LPNs, one (1) RN, and two (2) CMTs working on 10/29/11, demonstrated verification of staff knowledge of changes to policies for Notification of Physician and Change in a Resident's Condition. Immediate jeopardy was verified removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, scope and severity at a "D", while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures.	F 282	Medication errors will be monitored Monday through Friday by the ADON using the attached form, the Medical Director will review the findings weekly during rounds for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations, for their review and recommendations. The audit, "Physician Call Log" (copy attached), will be used 24 hours daily by staff when placing a call to a physician. These will be checked weekly by the ADON and a summary submitted monthly to the QA Committee for their review and recommendations. A new audit, "Death of a Resident" has been implemented in order to assure that calls have been made to the coroner when indicated and in a timely manner. The ADON will review the data each morning Monday through Friday and report findings monthly to the QA Committee for their review and recommendations.	
F 333 SS=J	483.26(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) resident of thirteen (13) sampled residents were free from any significant medication errors. The facility failed to follow the Administration	F 333		12-1-11

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Event ID: 611U11

Facility ID: 100242

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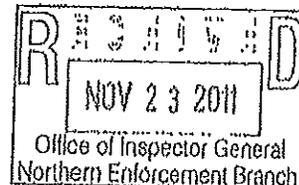
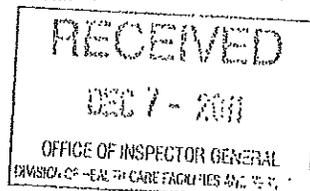
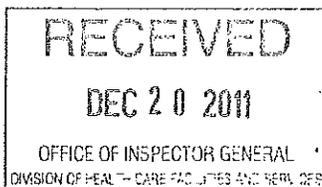
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F 333	<p>Continued From page 43</p> <p>Medication policy. The facility failed to ensure staff was competent in administering medications. On 10/17/11 the facility administered two doses of Oxyfast (Morphine Solution, Narcotic) one at 4:00 PM and one at 8:00 PM. Each dose administered to Resident #1 was twenty (20) times the physician ordered dose which jeopardized the health and safety of the resident. Resident #1 expired on 10/18/11 at 3:06 AM. Additionally the facility failed to ensure that the appropriate syringes for routes of medication administration were available to administer medications per the physician's order. The facility's failure to ensure residents were free of significant medication errors placed the residents in a situation that is likely to cause serious injury, harm, impairment, or death to a resident.</p> <p>The facility provided an acceptable credible allegation of compliance (AOC) on 10/28/11. Immediate Jeopardy was verified removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 483.25 Quality of Care, scope and severity at a "D", while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures.</p> <p>The findings include:</p> <p>Record review of the facility policy for Administering Medications revealed if a dosage is believed to be inappropriate or excessive for a resident, or a medication was identified as having</p>	F 333	<p>1. The RN on duty placed a call to the attending physician at approximately 12:00am to notify him of the med error and requesting him to call her. He did not and she made no subsequent calls attempting to reach him. The RN also called the DON, notified her of the medication error, no action was taken. No attempt was made immediately to notify the family of the medication error.</p> <p>2. Any resident who had an order for a small dose of liquid medication could potentially have been affected. However, none were affected. Physician orders were checked to identify all residents who had small dosage and liquid medication orders as any of those residents could have been affected by this practice. 180 orders were identified and 3 of them were changed for clarification that had inconsistent terminology between the physician's order and the medication label. Specifically, an order for Resident #6 was written, "Lorazepam 2MG/ML soln give 0.5ml sublingual every am for anxiety". The box label read, "Give 1/2ml (1mg) po every morning and every 2 hrs PRN". The box was corrected to read, "Give 0.5ml orally every morning, give 0.5 ml orally every 2 hours prn". The order for</p>	

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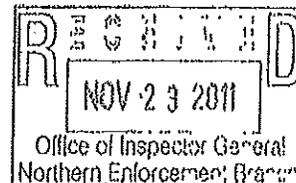
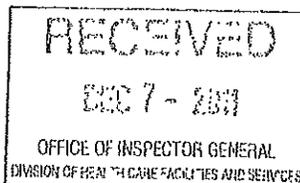
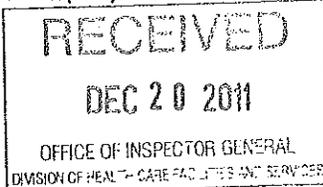
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F 333	<p>Continued From page 44</p> <p>potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication should contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns.</p> <p>Record review for Resident #1 revealed an admission date of 04/12/11 and diagnoses: Altered Mental State, Chronic Renal Failure, and Right Femoral Neck Fracture (hip fracture). The facility readmitted the resident on 10/13/11. Hospice care was initiated for Resident #1 on 10/14/11. A physician's order was written on 10/14/11 for Oxyfast 20 milligrams (mg) per milliliter (ml); give 2.5 milligrams every four (4) hours routine, and every hour as needed for pain or shortness of breath.</p> <p>Interview with LPN #3, on 10/22/11 at 11:35 AM, revealed she could not calculate the dose ordered, she reported she needed to give 2.5 ml and could not administer that amount with syringe provided by pharmacy. She consulted the LPN on duty and was told she would need three (3) one cc. syringes. However, she remained uncertain as to the amount to provide and did not consult with any other nurses or pharmacy. She was not sure who was responsible to contact the physician of medication errors.</p> <p>Interview with LPN #1, on 10/20/11 at 11:00 AM, revealed he looked at the box and told LPN #3 2.5cc was the appropriate dose to give, LPN #3 told him the pharmacy only sent these two small syringes and he told her to get another one because she would need three (3) 1cc syringes to give the dose. He saw 2.5 mg and read the dose</p>	F 333	<p>Resident #5 read, "Lorazepam Intensol 2MG/ML. Give 0.25 ml (0.5mg) through g tube every 4 hours as needed for anxiety." Medication box label read, "give 1/4ml (0.5mg.)" It was changed on box to read, "give 0.25ml via g-tube every 4 hours as needed for anxiety and restlessness". The third resident's order read, Oxyfast 20mg/ml po/sl every one hour prn for SOA". The order was changed to match the label so that they both read, "Give 0.5ml (10mg) po/sl) every hour prn for SOA". (Refer to attachment"</p> <p>Both LPNs who were involved in the error were suspended initially and ultimately terminated.</p> <p>3. Mandatory inservices were conducted on 10/18/11 at 2:30 and 3:30pm for all nursing staff. The CNAs attending only the HIPAA portion. Topics covered were Five Rights of Medication Administration with emphasis on dosage calculation by our consultant pharmacist from D&R Pharmacare; Identifying and Managing Medication Errors and Adverse Consequences by the DON; Med dosage calculation test and discussion by MDS Coordinator from the home office and HIPAA and the privacy rule by the Administrator (refer to attachments). "Care of the Hosparus Residents" and "Medication Administration" were</p>		

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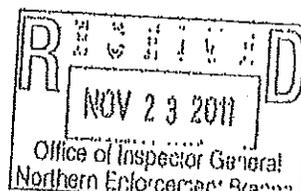
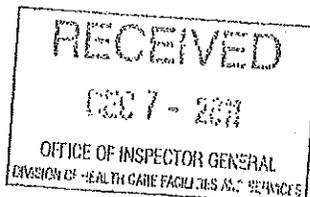
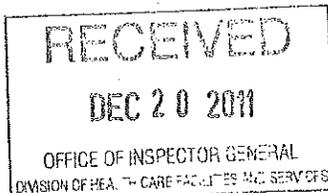
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F 333	<p>Continued From page 46</p> <p>as 2.5 ml. He told LPN #3 wrong as he was distracted during their conversation.</p> <p>Record review of the facility narcotic record for Resident #1 revealed at 4:00 PM on 10/17/11, LPN #3 administered 2.5 milliliters (mls) of Oxyfast which was the equivalent of 60 mgs, rather than 0.125 ml which would equal the physiolan ordered dose of 2.5 mgs. LPN #3 repeated the dose at 8:00 PM and administered 2.5 mls of Oxyfast to Resident #1.</p> <p>Review of the Resident Incident Report dated 10/18/11 revealed the resident was administered Oxyfast 2.5 ml instead of ordered dose of 2.5 mg at 4:00PM and 8:00PM on 10/17/11. Action taken indicated the physiolan was notified on 10/18/11 at 9:50AM. Disposition: observation. Administration review was dated 10/18/11.</p> <p>Record review of the facility Departmental Notes, dated 10/17/11 at 9:55 PM, documented by LPN #3 revealed Resident #1 was resting in bed with respirations even and unlabored. The next entry in the Departmental Notes was on 10/18/11 at 4:41 AM, documented by RN #2 which stated Resident #1 was found to be absent of respirations, pulses, and movement, with a time of death 3:06 AM.</p> <p>Interview with the Attending Physician, on 10/21/11 at 9:25 AM revealed the amount of narcotic the resident received could lead to death.</p> <p>Interview, on 10/21/11 at 9:15 AM, with the Medical Director revealed the large dose of the narcotic could have caused the death of Resident #1.</p>	F 333	<p>presented as mandatory inservice for All staff on 10/21/11 at 3:00pm, 10/22/11 at 2:00, 3:00 and 7:30pm and 10/24/11 at 11:00am and 1:00pm. These were presented by education staff from Hosparus. Nurses and CMTs were given a post test with all achieving 100%. Care of the Hosparus resident will also be covered in new employee orientation and annually for all nursing staff.</p> <p>Mandatory Inservice to address policies revised by the administrator, DON and ADON, "Charting and Documentation", "Death of a Resident", "Identifying and Managing Medication Errors and Adverse Consequences", and "Change of Resident's Condition" were presented by the administrator 10/23/11 at 6:00pm, 10/24/11 at 8:00am, 2:30 and 3:30pm and by the staff development coordinator on 10/25/11 at 11:00am, 1:40 and 2:30pm. These same policies will receive increased emphasis during new employee orientation.</p> <p>Appropriate size syringes for small doses of liquid medication are now kept in stock in the medication room. The consultant pharmacist provided an "On the Spot" inservice re: Narcan, its purpose and availability in the emergency box in the medication room. Med Pass observations and medication</p>		



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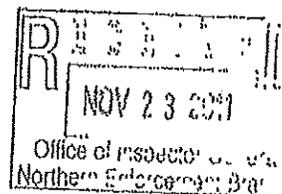
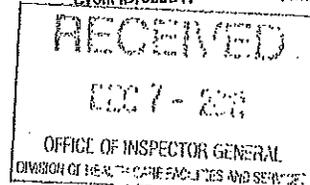
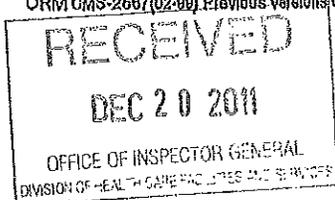
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	<p>Continued From page 46</p> <p>Record review of a Medication Administration Staff In-Service on 10/18/11 found the nursing staff responsible for medication administration was provided education regarding The Five Rights of Medication Administration and a test which included one (1) medication calculation question. Staff was provided with a Physiolan order: 20 mg/ml, give 2.5 mg every eight (8) hours, and staff was required to calculate the volume of the dose to be administered. Record review of the test results found that eighteen (18) staff completed the medication test, and seven (7) staff (thirty-five percent) was unable to provide the correct response of 0.125 ml.</p> <p>Interview, on 10/20/11 at 10:25 AM, with the Administrator revealed a staff In-service was provided to nursing staff responsible for medication administration on 10/18/11. The Administrator stated the In-service was provided as a review of the Five Rights of Medication Administration and staff was tested with one (1) medication calculation question. The Administrator reported the test results were, "Alarming," and suggested further staff training would be necessary.</p> <p>Observation, on 10/21/11 at 2:40 PM, with RN #1 and the Pharmacist revealed RN #1 said she was unable to administer a dose of Oxyfast .25 ml because the syringe provided by the Pharmacy did not have the correct calibrations to measure the dose precisely. However, Interview with the pharmacy and Administrator revealed they were not aware of this problem.</p> <p>Interview, on 10/21/11 at 2:40 PM, with the</p>		<p>dosage calculation have been added to new employee orientation and annually at the time of evaluation for all nurses and CMTs.</p> <p>4. Med Pass observations and dosage calculations have been added to New Employee Orientation, will be conducted annually with each nurse and CMT at the time of their evaluation. Six randomly selected nurses or CMTs will also be observed during medication administration and tested for dosage calculations each quarter. Findings will be reported to the QA Committee monthly.</p> <p>Medication errors will be monitored Monday through Friday by the ADON using the attached form, the Medical Director will review the findings weekly during rounds for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations for their review and recommendations.</p>	

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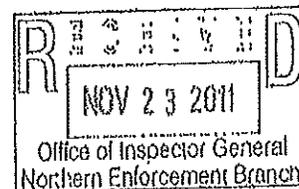
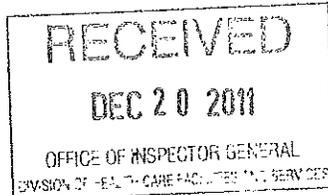
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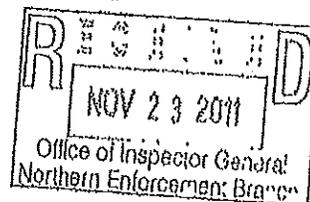
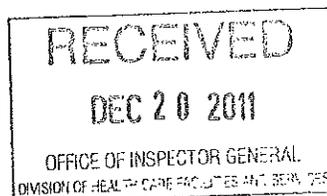
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F 333	<p>Continued From page 47</p> <p>Pharmacist revealed that if RN #1 called to explain a dosage could not be administered because the syringe provided by the Pharmacy did not have the correct calibrations to measure the exact dose, he would advise the nurse to call the Attending Physician to obtain an order for a dose that could be measured with the syringe that had been provided by the Pharmacy.</p> <p>Interview, on 10/21/11 at 4:00 PM, with Unit Manager (UM) #2 revealed nursing staff responsible for medication administration was not required to pass a medication administration test prior to hire at the facility.</p> <p>Interview, on 10/21/11 at 1:25 PM, with the Pharmacy General Manager, and the Contracted Staff Pharmacist revealed that medications are labeled with the intention that the Nurse or CMT would not need to calculate a dose of medication. The Contracted Staff Pharmacist said medication administration audits were done upon request of the facility, and was not sure when the audits were last completed.</p> <p>Interview, on 10/22/11 at 11:36 AM, with LPN #3 revealed the medication error/overdose of Resident #1 was discovered during the narcotic count at the end of the 3:00 PM-11:00 PM shift on 10/17/11. LPN #3 said she did not assess Resident #1, report the medication error to the Charge Nurse, initiate the medication error report, notify the Attending Physician, or notify the family. LPN #3 said she did not understand the severity of the medication error/overdose until she spoke with the Administrator on 10/18/11. LPN #3 said she learned in Nursing school that too much of a narcotic could hurt a resident or be fatal, and was</p>	F 333	<p>AMENDED POC</p> <p>1. . The RN on duty placed a call to the attending physician at approximately 12:00am to notify him of the med error and she requested him to call her. He did not. She made no further attempts to reach him. The RN also called the DON, notified her of the medication error, no action was taken. No attempt was made immediately to notify the family of the medication error.</p> <p>2. Any resident who had an order for a small dose of liquid medication could potentially have been affected. However, none were affected. Physician orders were checked to identify all residents who had small dosage and liquid medication orders as any of those residents could have been affected by this practice. 180 orders were identified and 3 of them were changed for clarification that had inconsistent terminology between the physician's order and the medication label.</p>	12/19/11	



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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 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG F 333	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 333	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued From page 48</p> <p>not aware of any medical treatment available to reverse a narcolepsy overdose. LPN #3 said she felt "stressed" after learning of the medication error/overdose and needed to go home.</p> <p>Interview, on 10/22/11 at 9:30 AM, with the Administrator revealed no annual competencies were performed by the facility to evaluate medication administration competency.</p> <p>Review of the allegation of compliance, dated 10/28/11, and interview with the Administrator on 10/29/11 at 9:00 AM, and the Director of Nursing on 10/29/11 at 2:30 PM, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. Mandatory staff in-services were provided to all staff responsible for medication administration on 10/18/11, and the facility provided documentation of the content which included a review of the Five Rights of Medication Administration. 2. Mandatory staff in-services were provided between 10/21/11 and 10/24/11, to educate staff on the care of Hospice residents and medication administration. The facility provided evidence of the content provided to staff and results of the post-test. Staff were not permitted to work without completion of the in-service and score of 100% on the medication administration post-test as of 10/28/11. 3. The facility implemented a process of medication administration observations and testing for calculation of small medication dosage to be conducted with every new hired RN, LPN, or CMT during the orientation process by the 		<p>All medication error reports were reviewed from 10/18/11 through 12/5/11. There were 6 errors in those 17 days, a total of 23,443 doses administered for an error rate of 0.02559. There were no adverse effects to any resident as a result of any of these errors.</p> <p>3. Mandatory In-services were conducted on 10/18/11 at 2:30 and 3:30pm for all nursing staff. Topics covered were Five Rights of Medication Administration with emphasis on dosage calculation by our consultant pharmacist from D&R Pharmacare; Identifying and Managing Medication Errors and Adverse Consequences by the DON; Med dosage calculation test and discussion by MDS Coordinator from the home office.</p> <p>"Care of the Hospice Residents" and "Medication Administration" were presented as mandatory in-service for All staff on 10/21/11 at 3:00pm, 10/22/11 at 2:00, 3:00 and 7:30pm and 10/24/11 at 11:00am and 1:00pm. These were presented by education staff from Hospice. Nurses and CMTs were given a post test with all achieving 100%. Care of the Hospice resident will also be covered in new employee orientation and annually for all nursing staff.</p>	



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F 333	Continued From page 49 Staff Development Coordinator or the ADON, and for all RN, LPN, and CMT during the annual evaluation beginning 10/28/11. 4. A process was developed to provide random medication administration observations and dosage testing monthly performed by the consulted pharmacist and the Assistant Director of Nursing. 5. The Quality Assessment and Assurance Committee met 10/24/11 to discuss medication errors and monitoring systems to prevent future significant medication errors, and the process for monitoring of medication errors was revised. The facility began monitoring/tracking medication errors, and developed a tool to monitor medication errors. The Assistant Director of Nursing or the on-call nurse was assigned the responsibility for review of all medication errors daily, and review the medication errors with the Medical Director weekly for three months. Immediate Jeopardy was verified to be removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 483.26 Quality of Care, scope and severity at a "D", while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 333	Mandatory inservice to address the policy, "Identifying and Managing Medication Errors and Adverse Consequences", revised by the administrator, DON and ADON, was presented by the administrator 10/23/11 at 6:00pm, 10/24/11 at 8:00am, 2:30 and 3:30pm and by the staff development coordinator on 10/25/11 at 11:00am, 1:40 and 2:30pm. This policy will receive increased emphasis during new employee orientation. Appropriate size syringes for small doses of liquid medication are now kept in stock in the medication room. The consultant pharmacist provided an "On the Spot" inservice re: Narcan, its' purpose and availability in the emergency box in the medication room. Med Pass observations and medication dosage calculation have been added to new employee orientation and annually at the time of evaluation for all nurses and CMTs. 4. Med Pass observations and dosage calculations have been added to New Employee Orientation, will be conducted annually with each nurse and CMT at the time of their evaluation. Two randomly selected nurses or CMTs will also be observed during medication administration and tested for dosage	
F 431 SS=E		F 431		

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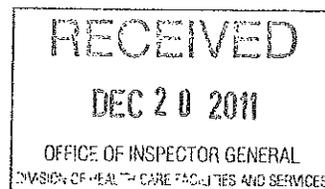
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Northern Kentucky Region

F333 PAGE 50A

AMENDED Poc

calculation each month by the consultant pharmacist and the DON or SDC.

The medical director is a member of the QA&A Committee and regularly attends the meetings and offers valuable input. The administrator chairs the Committee and reviews all data before it is discussed at the meeting. She also participates in decision making for actions and length of time audits will be conducted.



AMENDED POC (2)

7333

F 333 3. The policy, "Identifying and Managing Medication Errors and Adverse Consequences" was also revised by the administrator, DON and ADON with final approval by the medical director in October 2011 with implementation on October 26. These changes direct staff to report medication errors with potential adverse consequences to the attending physician immediately. As in the previous policy the DON will be contacted and likewise contact the medical director if the attending physician does not respond in an hour. The medical director has advised that he will resolve the issue and also contact the attending physician re: his/her noncompliance.

4. Med Pass Observations using a tool presented by Omnicare Long Term Care Pharmacy through their consultant and approved by QA&A is used to conduct observations with all newly hired nurses and CMTs during their orientation process and with every nurse and CMT as part of their annual evaluation. Six randomly selected nurses or CMTs will also be observed each quarter by the consultant pharmacist and ADON/SDC. (the ADON/SDC were trained by the consultant pharmacist re: use of these tools.) A dosage calculation test developed by the DON and approved by the pharmacist and medical director will be used at these same times. This audit will provide education to the staff as well as identify their performance level. They must achieve 100% in both areas in order

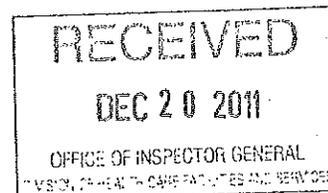
7333

to administer medications. Results will be reported monthly to QA&A for their review and recommendations. The administrator will review the results of each as they are completed. This process was implemented in November 2011.

Effective November 1 the occurrence of medication errors is being monitored Monday through Friday by the ADON using a form developed by the home office MDS Coordinator and approved by QA&A. The administrator discussed the use of the form with the ADON. The Medical Director and administrator will review the findings weekly for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations

7333

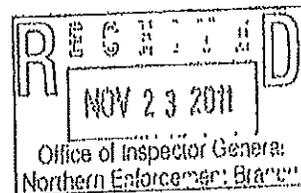
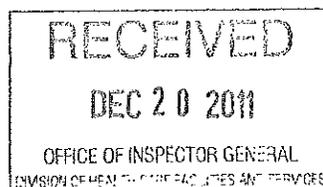
4/7/11
date changed to
12-13-11
per Jan Strong
by PB 12-21-11



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F 431	Continued From page 62 was propped open with a trash can and a housekeeper was in the room alone cleaning. Further observation of the medication room revealed multiple syringes and needles unlooked in a cabinet and eight (8) packages of medications lying out on a counter. The medications included twenty (20) Lidoderm Patches (each containing seven hundred [700] milligrams of Lidocaine [pain reliever]), one (1) Advair Discus (improve breathing), (53) Risperidone .25mg. tablets (antipsychotic which may cause low blood pressure), twenty-one (21) Fluoxetine 20mg. tablets (antidepressant), seventeen (17) Cymbalta 30mg. tablets (antidepressant), twenty-six (26) 2.5mg. Glyburide tablets (anti-diabetic agent), five (5) 325mg. Acetaminophen tablets (pain reliever), and thirty five (35) 100mg. Benzonatate tablets (cough suppressant). Continued interview with the ADON, on 10/28/11 at 9:30 AM, revealed serious health problems could potentially occur if the housekeeper took any or all of the medications lying out on the counter in the medication room or gave them to others. She also stated no unlicensed medical personnel should have access to multiple syringes and needles. Interview with the facility's Pharmacy Manager, on 10/28/11 at 9:50 AM, revealed the medications (any of them alone or in combination) lying on the counter in the first floor medication room and accessible to the housekeeper on 10/28/11 were potentially hazardous medications.	F 431	4. The unit managers will be held accountable to see that there is compliance with this policy. Administrator, DON and ADON will observe for compliance when making rounds and will note their observations on the Medication Room Audit, copy attached. This will be submitted to the QA&A Committee monthly beginning January 18, 2012 for their review and recommendations. AMENDED POC (2)	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490	3. There were no policy changes made, however, a flyer was placed in the communication book on each unit by the DON entitled, "Medication Room Cleaning Procedures" advising nursing staff of the regulation that no one was permitted in the medication room alone other than a nurse or CMT, this includes the housekeepers when they clean the room. The DON discussed the issue with the director of environmental services as well as changing the time for cleaning to a time when nurses/CMTs would be more readily available to stay in the room. He, in turn, discussed the issue and regulation with the housekeeping staff.	



Pg. 53a

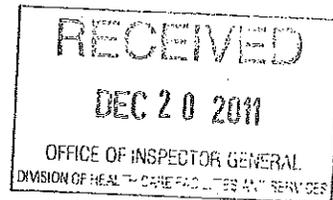
#431

Temporary signs (12/8) and now permanent signs (12/11) were posted on the med room doors, "Authorized Personnel Only"

4. The unit managers are responsible to see that there is compliance with the policy "Storage of Medications" in which Item #10 states, " 10. Only persons authorized to prepare and administer medications shall have access to the medication room, including the keys." "A Medication Room Audit" form was developed by the home office MDS Coordinator. This form has been placed in the medication room on each floor for use by the administrator, DON and ADON when they make random rounds. This form will be submitted monthly to QA&A beginning January 18, 2012 for their review and recommendations.

7/4/31

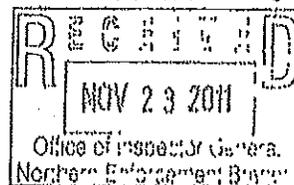
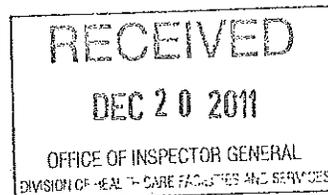
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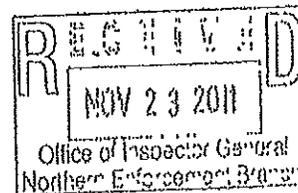
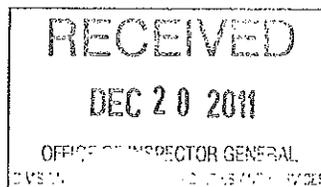
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2011
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F 431	<p>Continued From page 50</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologoals used in the faclilty must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologoals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to permit only authorized personnel access to one (1) of two (2) locked medication rooms. A facility</p>	F 431	<ol style="list-style-type: none"> 1. No residents were affected by this practice. The Unit Managers were immediately advised that per existing policy, "Storage of Medications" (copy attached), Item # 10, "Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys". 2. While no residents were affected there was potential for any resident to be affected if their medication was taken from the room by the housekeeper or tampered with in some way. Also, residents might have been harmed if they enter the medication room. 3. The DON communicated with the Director of Environmental Services personally on 11/21/11 and advised him that the housekeepers would be required to clean the medication rooms only at a time when a nurse or CMT was present in the room. A message (copy attached) was placed in the Communication Book on each unit by the DON on 11/21/11 advising them of this regulation and hwy it exists. 4. The unit managers will be held accountable to see that there is compliance with this policy. Administrator, DON and ADON will observe for compliance when making rounds. 	12-1-11



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F 431	<p>Continued From page 61</p> <p>housekeeper was observed alone in the first floor medication room with the door propped open and with access to multiple syringes, needles, and unlocked medications.</p> <p>The findings include:</p> <p>Review of the facility policy, Storage of Medications, dated August 2009, revealed 10. Only persons authorized to prepare and administer medications shall have access to the medication room.</p> <p>Interview with the housekeeper, on 10/28/11 at 8:20 AM, revealed she was unaware of the facility policy which did not allow her access to the medication room.</p> <p>Interview with the Licensed Practical Nurse Unit Manager, on 10/28/11 at 8:25 AM, revealed she was aware of the facility policy regarding who had access to the medication room, but did not think it applied to facility housekeeping staff.</p> <p>Interview with a Registered Nurse, on 10/28/11 at 8:30 AM, revealed she also was not aware the facility policy applied to the housekeeping staff.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/28/11 at 9:30 AM, revealed she was aware of the facility policy regarding unauthorized personnel not being allowed in the medication room and she did not know why the housekeeping staff was allowed in the medication room.</p> <p>Observation of the facility's first floor medication room, on 10/28/11 at 7:20 AM, revealed the door</p>	F 431	<p>AMENDED POC</p> <ol style="list-style-type: none"> 1. No residents were affected by this practice. The Unit Managers were immediately advised that per existing policy, "Storage of Medications" (copy attached), item # 10, "Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys". 2. While no residents were affected there was potential for any resident to be affected if their medication was taken from the room by the housekeeper or tampered with in some way. Also, residents might have been harmed if they entered the medication room. 3. The DON communicated with the Director of Environmental Services personally on 11/21/11 and advised him that the housekeepers would be required to clean the medication rooms only at a time when a nurse or CMT was present in the room. <p>A message (copy attached) was placed in the Communication Book on each unit by the DON on 11/21/11 advising them of this regulation.</p> <p>Temporary signs, "Authorized Personnel Only" have been posted on the doors of the medication rooms awaiting permanent signage that has been ordered.</p>	12/9/11



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F 490	<p>Continued From page 53</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to manage and utilize resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to ensure staff was knowledgeable, trained and competent in the administration of medications. The facility on 10/17/11, two narcotic overdoses that was twenty (20) times the physician's order. The LPN was unable to accurately calculate the prescribed dosage. Additionally the facility failed to ensure staff was knowledgeable and trained to facility policies for notification of the physician and family and significant medication error. This failure resulted in the physician receiving director not being notified immediately of the two significant medication errors resulting in Resident #1 having two narcotic overdoses. The facility failed to seek emergency medical treatment for Resident #1. The facility failed to prevent neglect and failed to identify neglect and investigate. The facility's failure to prevent significant medication errors leading to an overdose, failure to identify, investigate and report allegations of neglect and failure to provide training to staff placed residents</p>	F 490	<p>1. The resident was assessed after the error was identified (3 hours after the second wrong dose) by the LPN and RN and vital signs were taken and recorded on a "slip of paper" by the CNA but none of them documented their findings in the medical record. The RN placed a call to the attending physician and asked him to return the call. He did not and no subsequent attempts to reach him were made. The RN also called the DON and advised her of the medication error, no action was taken.</p> <p>2. Any resident who had an order for a small dose of liquid medication could potentially have been affected. However, none were affected. Physician orders were checked to identify all residents who had small dosage and liquid medication orders as any of those residents could have been affected by this practice. 180 orders were identified and 3 of them were changed for clarification that had inconsistent terminology between the physician's order and the medication label. Specifically, an order for Resident #6 was written, "Lorazepam 2MG/ML soln give 0.5ml sublingual every am for anxiety". The box label read, "Give 1/2ml (1mg) po every morning and every 2 hrs PRN". The box was corrected to read, "Give 0.5ml</p>	12-1-11

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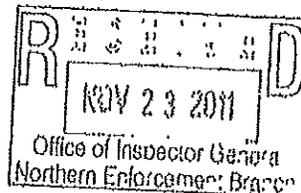
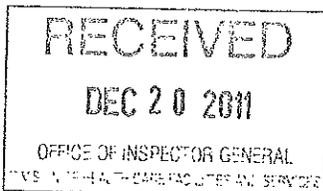
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F 490	<p>Continued From page 54</p> <p>In a situation that is likely to cause injury, harm, impairment, or death to a resident.</p> <p>The facility provided an acceptable credible allegation of compliance (AOC) on 10/28/11. Immediate Jeopardy was verified removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 483.10 Resident Rights, 42 CFR 483.13 Resident Behavior, 42 CFR 483.20 Resident Assessment, 42 CFR 483.25 Quality of Care, 42 CFR 483.75 Administration, scope and severity at a "D", and 42 CFR 483.60 Pharmacy Services, scope and severity at a "E", while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures.</p> <p>The findings include:</p> <p>Review of the facility's policy for Change in a Resident's Condition or Status revealed the Attending Physician, and family were to be notified by the facility of an accident or incident which involved the resident.</p> <p>Review of the facility's policy for Identifying and Managing errors and Adverse Consequences revealed the facility was responsible to report medication errors with adverse clinical consequences to the resident's Attending Physician immediately.</p>	F 490	<p>orally every morning, give 0.5 ml orally every 2 hours prn". The order for Resident #5 read, "Lorazepam Intensol 2MG/ML. Give 0.25 ml (0.5mg) through g tube every 4 hours as needed for anxiety." Medication box label read, "give 1/4ml (0.5mg.)" It was changed on box to read, "give 0.25ml via g-tube every 4 hours as needed for anxiety and restlessness". The third resident's order read, Oxyfast 20mg/ml po/sl every one hour prn for SOA". The order was changed to match the label so that they both read, "Give 0.5ml (10mg) po/sl) every hour prn for SOA". (Refer to attachment)</p> <p>Any resident who was subjected to abuse or neglect of any type had the potential to be affected by this deficient practice. However, no other residents were affected.</p> <p>The LPN who administered the overdose and the LPN from whom she sought advice were both suspended pending the investigation on 10/18/11 and 10/20/11 respectively (he did not work from time of incident until suspension), ultimately terminated on 10/24/11 and reported to the Kentucky Board of Nursing on 10/24/11. The LPN who administered the wrong dose was sent for a drug screen, results were negative (copy attached).</p>	



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: 186137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUEGHEL BANK ROAD LOUISVILLE, KY 40218	
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F 490	<p>Continued From page 65</p> <p>Review of the facility's policy for Reporting Resident Abuse revealed the facility was responsible to immediately report any incident or incident of suspected resident neglect, and stated incidents would be investigated and findings of abuse would be reported to the State Agency.</p> <p>Record review revealed the facility readmitted Resident #1 on 10/13/11 with diagnosis of Right Hip Fracture. On 10/14/11, a physician order was documented for Oxyfast (morphine solution) 20 milligrams per milliliter (mg/ml), give 2.5 mg every four (4) hours routine, and hourly as needed for pain or shortness of air. At 4:00 PM on 10/17/11, LPN #3 administered 2.5 milliliters (mls) of Oxyfast which was the equivalent of 60 mgs, rather than 0.125 ml which would equal the physician ordered dose of 2.5 mgs. LPN #3 repeated the dose at 8:00 PM and administered 2.5 mls of Oxyfast to Resident #1. There was no documented evidence the facility notified the physician, medical director or family immediately after the significant medication error was identified. There was no documented evidence the facility staff sought emergency medical treatment to reverse the effects of the narcotic overdose. Resident #1 expired on 10/18/11. Refer to F167, F224, F225, F281, F282, and F333.</p> <p>Interview, on 10/22/11 at 11:36 AM, with LPN #3 revealed she did not understand the ordered dosing of the narcotic. She asked the desk nurse LPN #1 who instructed her to use three (3) 1cc syringes to administer the medication. LPN #3 still thought she need to administer 2.5 ml.</p> <p>Interview with LPN #1 on 10/20/11 at 11:00 AM, revealed LPN #3 asked him how much she</p>	F 490	<p>3. Mandatory inservices were conducted on 10/18/11 at 2:30 and 3:30pm for all nursing staff. The CNAs attending only the HIPAA portion. Topics covered were Five Rights of Medication Administration with emphasis on dosage calculation by our consultant pharmacist from D&R Pharmacare; Identifying and Managing Medication Errors and Adverse Consequences by the DON; Med dosage calculation test and discussion by MDS Coordinator from the home office and HIPAA and the privacy rule by the Administrator (refer to attachments). "Care of the Hosparus Residents" and "Medication Administration" were presented as mandatory inservice for all staff on 10/21/11 at 3:00pm, 10/22/11 at 2:00, 3:00 and 7:30pm and 10/24/11 at 11:00am and 1:00pm. These were presented by education staff from Hosparus. Nurses and CMTs were given a post test with all achieving 100%. Care of the Hosparus resident will also be covered in new employee orientation and annually for all nursing staff.</p> <p>Mandatory inservice to address policies revised by the administrator, DON and ADON, "Charting and Documentation" "Death of a Resident", "Identifying and Managing Medication Errors and Adverse Consequences", and "Change</p>	

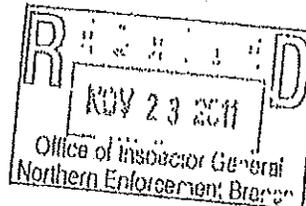
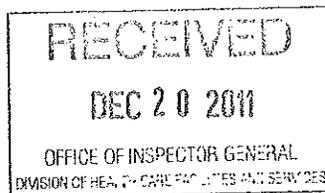
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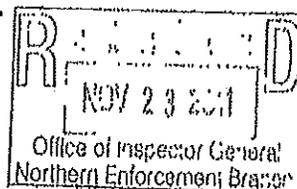
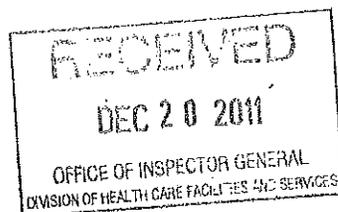
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2011	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
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F 490	<p>Continued From page 66</p> <p>should give and he told her she needed three (3) 1cc syringes to give the dose. He saw 2.6 mg and read the dose as 2.5 ml. He stated he told the LPN wrong because he was distracted during their conversation.</p> <p>Review of facility provided in-service documentation, revealed an in-service was completed on 10/18/11 for nursing staff responsible for medication administration which included a review of the Five Rights of Medication Administration and a test with one (1) medication dose calculation. Eighteen (18) staff members were tested, and it was determined that seven (7) staff could not calculate the correct dose to administer.</p> <p>Record review of the facility staffing forms and medication records, revealed three (3) of seven (7) staff members that could not accurately perform a medication dose calculation, provided medications to residents on subsequent shifts after the Medication Administration In-service provided on 10/18/11.</p> <p>Interview with the Attending Physician, on 10/21/11 at 9:25 AM, revealed he was not aware of the amount of narcotic administered to Resident #1 and stated that amount of the narcotic could lead to death.</p> <p>Interview with the Medical Director, on 10/21/11 at 9:15 AM revealed treatment was available to reverse the effect of the narcotic overdose received by Resident #1. The large dose of narcotic could have caused the death of Resident #1.</p>	F 490	<p>of Resident's Condition" were presented by the administrator 10/23/11 at 6:00pm, 10/24/11 at 8:00am, 2:30 and 3:30pm and by the staff development coordinator on 10/25/11 at 11:00am, 1:40 and 2:30pm. These same policies will receive increased emphasis during new employee orientation.</p> <p>"Abuse and Neglect; Medical Director" (copies attached) mandatory inservice was conducted for all nurses and CMTs on Friday 10/28/11 at 10 and 11:00am, 2 and 3pm. Those staff members who were not present were contacted by telephone and received the same information. (100% "attendance was achieved"). These were conducted by the administrator/social service professional with emphasis on what constitutes neglect and how to prevent it; who serves as the facility Medical Director and the need to notify him in such circumstances by notifying the nurse manager on call.</p> <p>The administrator has full understanding of her error in not recognizing this neglect and fully understands the various aspects of neglect and the need for reporting same in the future.</p> <p>All allegations of resident abuse/neglect will be reported to the appropriate state agencies in a timely manner.</p>	



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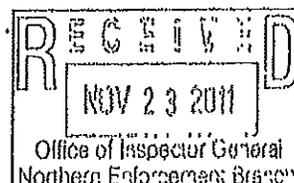
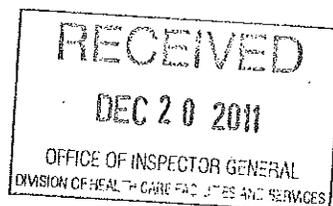
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F 490	<p>Continued From page 57</p> <p>Interview with RN #2, on 10/20/11 at 11:40 AM, revealed she was told by the Administrator on 10/20/11 that when she was unable to contact the Attending Physician, she could have called the Medical Director. RN #2 said she did not know she had the authority to contact the Medical Director.</p> <p>Interview with LPN #2, on 10/20/11 at 11:30 AM, revealed she was not sure of the details of the facility policy for Change In Resident Condition or Status or the facility policy for Managing Medication Errors and Adverse Consequences.</p> <p>Interview, on 10/22/11 at 9:30 AM, with the Administrator revealed she reported the medication error/overdose for Resident #1 to OIG because it was, "a huge medication error" which was followed by the death of a resident, and it seemed there could be a relationship between the medication error/overdose and the death of Resident #1. The Administrator said she could relate the failure of the nursing staff to notify the Attending Physician and family, and seek emergency treatment for Resident #1 as an example of resident neglect.</p> <p>Interview, on 10/28/11 at 2:40 PM, with the Attending Physician revealed he described neglect as, "not doing what should be done." The Attending Physician said LPN #2 and RN #2 should have continued efforts to report the medication error/overdose given to Resident #1 on 10/17/11. The Attending Physician said LPN #2 and RN #2 were responsible for the neglect of Resident #1 as a result of failure to notify the physician of the narcole overdose.</p>	F 490	<p>Med Pass observations and medication dosage calculation have been added to new employee orientation and annually at the time of evaluation for all nurses and CMTs.</p> <p>The QA Committee met on October 24, 2011 and discussed the immediate Jeopardy situation. Four audits, "Med Pass Observations and Small Dosage Calculations", "Physician Calls", "Medication Error and Notifications" and "Death of a Resident" were approved; an abuse audit was also added.</p> <p>4. An audit developed by the home office MDS Coordinator (copy attached) will be completed by the social service representative for all allegations of abuse, neglect or misappropriation of funds. Findings will be reviewed by the administrator and reported monthly to the Quality Assurance Committee for their review and recommendations. Med Pass observations and dosage calculations have been added to New Employee Orientation, will be conducted annually with each nurse and CMT at the time of their evaluation. Six randomly selected nurses or CMTs will also be observed during medication administration and tested for dosage calculations each quarter by the consultant pharmacist and the ADON/SDC (form attached). Findings will be reported to the QA Committee</p>	



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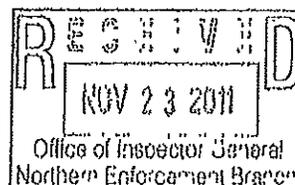
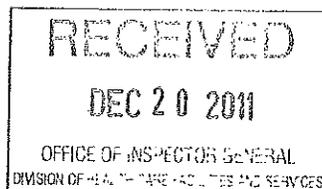
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F 490	<p>Continued From page 58</p> <p>Interview, on 10/28/11 at 8:50 AM, with the Administrator revealed she, as the Administrator of the facility believed she was solely responsible for the neglect in her failure to investigate and report the death of Resident #1. The Administrator said upon completion of the facility investigations, it became evident that multiple staff members neglected to do what was necessary to report the medication error/overdose and seek treatment for Resident #1 after the medication error/overdose on 10/17/11.</p> <p>Review of the Allegation of Compliance, dated 10/18/11, and interview with the Administrator on 10/29/11 at 9:00 AM, and the Director of Nursing on 10/29/11 at 2:30 PM, revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. Mandatory staff in-services were provided for staff responsible for medication administration on 10/18/11, and the facility provided documentation of the content which included a review of the Five Rights of Medication Administration. 2. Mandatory staff in-services were provided between 10/21/11 and 10/24/11, to educate staff on the care of Hospice residents and Medication Administration. The facility provided evidence of the content provided to staff and results of the post-test. Staff were not permitted to work without completion of the in-service and score of 100% on the medication administration post-test as of 10/28/11. 3. Staff received mandatory Abuse and Neglect Training on 10/28/11, and the facility provided documentation of 100% staff attendance. 	F 490	<p>monthly.</p> <p>Medication errors will be monitored Monday through Friday by the ADON using the attached form, the Medical Director will review the findings weekly during rounds for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations. The audit, "Physician Call Log" (copy attached), will be used 24 hours daily by staff when placing a call to a physician. These will be checked weekly by the ADON and a summary submitted monthly to the QA Committee for their review and recommendations. A new audit, "Death of a Resident" has been implemented in order to assure that calls have been made to the coroner when indicated and in a timely manner. The ADON will review the data each morning Monday through Friday and report findings monthly to the QA Committee for their review and recommendations.</p>		



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F 490	Continued From page 59 4. Revisions were made on to the facility policy for Identifying and Managing Medication Errors and Adverse Consequences and the facility policy for Change in a Resident's Condition or Status (revision date 10/2011); staff training began on 10/22/11 and concluded on 10/26/11. 5. The Quality Assessment and Assurance Committee met on 10/24/11 to discuss medication errors and implemented a change in the process to monitor medication errors. The Assistant Director of Nursing and/or the oncall nurse would be responsible for monitoring medication errors daily and review of medication errors weekly with the Medical Director for three (3) months. 6. Medication administration observations and testing for calculation of small medication dosages would be conducted with every new hired RN, LPN, or CMT during the orientation process by the Staff Development Coordinator or the ADON, and for all RN, LPN, and CMT at the time of annual evaluation beginning 10/28/11. 7. A process was developed to provide random medication administration observations and dosage testing monthly performed by the consulted pharmacist and the Assistant Director of Nursing beginning 10/28/11. 8. A process was developed and staff received in-service training on the need to notify the Nurse-on-Call of any resident's death to discuss the need to notify the Coroner. The facility implemented a process for the Assistant Director of Nursing to review all deaths at the facility to	F 490	AMENDED POC 1. It was not possible to correct this issue for resident #1 as he expired 7 hours following the administration of the second incorrect dosage of medication before corrective action was taken. As a final step to acknowledge the resident's right for an investigation the OIG was notified on 10/18/11 at 1:30pm by the DON and the coroner's office at 2:00pm on 10/19/11 by the administrator. 2. All incident/accident reports, medication error reports, lab reports and nurses notes for the time period of October 17 through October 29 were reviewed to identify situations in which the physician or family should have been called, if they were called, and was physician response timely. No other residents were found to be affected by this deficient practice. 3. The administrator contacted the coroner's office at approximately 2:00PM on October 18. The policy, Death of a Resident was revised by the administrator, DON and ADON and approved by the medical director. This revision provided instruction re: calling the coroner's office (copy attached).	12/9/11



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F 490	Continued From page 60 determine the need to report to the Coroner. Immediate Jeopardy was verified to be removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 483.10 Resident Rights, 42 CFR 483.13 Resident Behavior, 42 CFR 483.20 Resident Assessment, 42 CFR 483.26 Quality of Care, 42 CFR 483.76 Administration, scope and severity at a "D", and 42 CFR 483.60 Pharmacy Services, scope and severity at a "E", while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures.	F 490	The administrator, DON and ADON received training from the President of the company, a LNHA with 30 years experience, on 12/5/11 (refer to attached). Mandatory inservices for nurses and CMTs were conducted on 10/18/11 at 2:30 and 3:30pm. Topics covered were Five Rights of Medication Administration with emphasis on dosage calculation by our consultant pharmacist from D&R Pharmcare; Identifying and Managing Medication Errors and Adverse Consequences by the DON; Med dosage calculation test and discussion by MDS Coordinator from the home office (refer to attachments). "Care of the Hosparus Residents" and "Medication Administration" were presented as mandatory inservice for all staff on 10/21/11 at 3:00pm, 10/22/11 at 2:00, 3:00 and 7:30pm and 10/24/11 at 11:00am and 1:00pm. These were presented by education staff from Hosparus. Nurses and CMTs were given a post test with all achieving 100%. Care of the Hosparus resident will also be covered in new employee orientation and annually for all nursing staff. Mandatory inservice to address policies revised by the administrator, DON and ADON, "Charting and Documentation" "Death of a Resident", "Identifying and	

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Managing Medication Errors and Adverse Consequences", and "Change of Resident's Condition" were presented by the administrator 10/23/11 at 6:00pm, 10/24/11 at 8:00am, 2:30 and 3:30pm and by the staff development coordinator on 10/25/11 at 11:00am, 1:40 and 2:30pm. These same policies will receive increased emphasis during new employee orientation.

"Abuse and Neglect; Medical Director" (copies attached) mandatory inservice was conducted for all nurses and CMTs on Friday 10/28/11 at 10 and 11:00am, 2 and 3pm. professional with emphasis on what constitutes neglect and how to prevent it; who serves as the facility Medical Director and the need to notify him in such circumstances by notifying the nurse manager on call. Those staff members who were not present for these two inservices were contacted by telephone and received the same information. (100% "attendance was achieved"). Subsequently those persons have signed the attendance rosters (attached) to further verify their participation.

The administrator has full understanding of her error in not recognizing this neglect and fully understands the various aspects of neglect and the need for reporting same in the future.

All allegations of resident abuse/neglect will be reported to the appropriate state agencies in a timely manner. A mini inservice was presented by the administrator to the two social service professionals re: reporting requirements on 12/6/11 (refer to attached).

Med Pass observations and medication dosage calculation have been added to new employee orientation and annually at the time of evaluation for all nurses and CMTs.

The QA Committee met on October 24, 2011 and discussed the immediate Jeopardy situation. Four audits, "Med Pass Observations and Small Dosage Calculations", "Physician Calls", "Medication Error and Notifications" and "Death of a Resident" were approved;

an abuse audit was also added.

4. An audit developed by the home office MDS Coordinator (copy attached) will be completed by the social service representative for all allegations of abuse, neglect or misappropriation of funds. Findings will be reviewed by the administrator and reported monthly to the Quality Assurance Committee for their review and recommendations. Med Pass observations and dosage calculations have been added to New Employee Orientation, will be conducted annually with each nurse and CMT at the time of their evaluation. Two randomly selected nurses or CMTs will also be observed during medication administration and tested for dosage calculations each month by the consultant pharmacist and the

ADON/SDC (forms attached). Findings will be reported to the QA Committee monthly.

Medication errors will be monitored Monday through Friday by the ADON using the attached form, the Medical Director will review the findings weekly during rounds for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations. The audit, "Physician Call Log" (copy attached), will be used 24 hours daily by staff when placing a call to a physician. These will be checked weekly by the ADON and a summary submitted monthly to the QA Committee for their review and recommendations.

A new audit, "Death of a Resident" has been implemented in order to assure that calls have been made to the coroner when indicated and in a timely manner. The ADON will review the data each morning Monday through Friday and report findings monthly to the QA Committee for their review and recommendations.

The administrator chairs the QA&A Committee and reviews all data before it is presented to the committee and also participates in decisions re: compliance goal setting for each audit, actions to be taken and length of time to conduct the audits.

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PAGE 61 B

Those persons who are conducting the audits are trained by the administrator who also chairs the Committee and oversees the program.

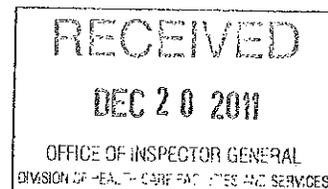
If repeated non compliance is identified prior to the QA&A meeting the person(s) involved will be subject to the corrective action process by their supervisor.

The Plan of Correction will be discussed by the administrator with the medical director, a representative from the home office and the managers on site who are responsible for the various areas addressed in the POC. The administrator will also discuss pertinent information from time to time with department heads in order to solicit their observations of practices. They will be asked to report negative findings to the administrator. The administrator will meet weekly for one month and then monthly with the DON and ADON to discuss compliance status with the POC.

The POC will be discussed in detail at the January 18, 2012 QA&A meeting with a partial month of data submitted for all new audits and all audits initiated will be presented with one full month of data at the February 15, 2012 QA&A meeting.

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AMENDED POC (2)

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contd.

F 490 3. The policy, "Identifying and Managing Medication Errors and Adverse Consequences" was also revised by the administrator, DON and ADON with final approval by the medical director in October 2011 with implementation on October 26. These changes direct staff to report medication errors with potential adverse consequences to the attending physician immediately. As in the previous policy the DON will be contacted and likewise contact the medical director if the attending physician does not respond in an hour. The medical director has advised that he will resolve the issue and also contact the attending physician re: his/her noncompliance. The policy "Death of a Resident" was reviewed and revised by the administrator, DON and ADON and inservices held with staff on 10/23, 24 and 25. Emphasis was placed on the need to determine if the coroner should be called and that the nurse on call should be notified to discuss this.

4. Med Pass Observations using a tool presented by Omnicare Long Term Care Pharmacy through their consultant and approved by QA&A is used to conduct observations with all newly hired nurses and CMTs during their orientation process and with every nurse and CMT as part of their annual evaluation. Six randomly selected nurses or CMTs will also be observed each quarter by the consultant pharmacist and ADON/SDC. (the ADON/SDC were trained by the consultant pharmacist re: use of these tools.) A dosage calculation test developed by the DON and approved by the pharmacist and medical director will be used at these same times. This audit will provide education to the staff as well as identify their performance

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level. They must achieve 100% in both areas in order to administer medications. Results will be reported monthly to QA&A for their review and recommendations. The administrator will review the results of each as they are completed. This process was implemented in November 2011. Effective November 1 the occurrence of medication errors is being monitored Monday through Friday by the ADON using a form developed by the home office MDS Coordinator and approved by QA&A. The administrator discussed the use of the form with the ADON. The Medical Director and administrator will review the findings weekly for 3 months and then as determined by the QA Committee. The QA Committee will review the findings monthly and make recommendations. A new audit, "Death of a Resident" was implemented 12/1 in order to assure that calls have been made to the coroner when indicated and in a timely manner. The ADON after discussing how to conduct the review has been reviewing the data each morning Monday through Friday and will report findings monthly to QA &A for their review and recommendations. The administrator will review the ADON findings weekly.

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12/19/11

date changed to
12-13-11
per Jan Shroy
by PB 12-21-11

