

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 0 10/29/2011
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 225	<p>Continued From page 21</p> <p>medication error which was followed by the death of the resident," and it seemed there could be a relationship between the medication error/overdose and the death of Resident #1. The Administrator defined neglect as "A failure to do something for someone."</p> <p>Record review of Resident #1 revealed the facility admitted the resident on 04/12/11 with diagnoses of: Altered Mental Status, and right femoral neck fracture (hip fracture). The facility readmitted the resident on 10/13/11 and was admitted to Hospice care on 10/14/11. On 10/14/11, an order was written for Oxyfast 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.</p> <p>Record review of the Resident Incident Report, dated 10/18/11 detailed an account of a medication error/overdose given to Resident #1 by LPN #3 on 10/17/11 which included written and signed statements from all staff involved in the medication error/overdose.</p> <p>Record review of the facility's narcotic record for Resident #1 revealed the resident received two (2) incorrect doses of Oxyfast (Morphine solution) on 10/17/11 at 4:00 PM and 8:00 PM. LPN #3 gave 2.5 milliliters (ml) of Oxyfast to Resident #1, rather than 0.125 ml as ordered by the physician which resulted in a narcotic overdose of Resident #1.</p> <p>Interview, on 10/22/11 at 11:35 AM, with LPN #3 revealed the medication error/overdose of Resident #1 was discovered during the narcotic count at the end of the 8:00 PM-11:00 PM shift on 10/17/11. LPN #3 said she did not assess</p>	F 225	<p>policies, "Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting Resident Abuse (Includes types of abuse) and Reporting Abuse to Facility Management" are reviewed and discussed during new employee orientation and annually. The Social Service representative now clearly understands that she will report allegations of abuse to the OIG as well as APS and that those situations reported to the OIG also require submission of a five day follow up final report.</p> <p>The policies, "Changes in a Resident's Condition or Status" and "Identifying and Managing Medication Errors and Adverse Consequences" were reviewed and revised (copies attached) by the administrator, DON and ADON. Mandatory inservice to review the revised policies was conducted on 10/22/11 at 7:30pm, 10/23/11 at 6:00pm, 10/24/11 at 8:00am and 9:30pm and 10/25/11 at 11:00am, 1:40pm and 2:30pm. These policies will also be presented and discussed in new employee general orientation (copy of orientation attached).</p> <p>All abuse and neglect allegations will be reported to the Social Service representative in a timely manner who will report them to APS and thoroughly</p>	
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2416 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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F 226	<p>Continued From page 22</p> <p>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 10/19/11. LPN #3 said she learned in Nursing school that too much of a narcotic could hurt a resident or be fatal, and was not aware of any medical treatment available to reverse a narcotic overdose. LPN #3 said she felt "stressed" after learning of the medication error/overdose and needed to go home.</p> <p>Interview with LPN #2, on 10/20/11 at 11:30 AM, revealed she told RN #2 who was the Charge Nurse, about the medication error/overdose, and said RN #2 made a call to the Attending Physician and the DON to report the medication error/overdose. However, record review of the nurses notes revealed the attending physician was contacted on 10/17/11 at 9:55 PM with no notice of the medication error/overdose. There was no further documentation of physician notification until the notice of death.</p> <p>Interview, on 10/20/11 at 11:40 AM, with RN #2 revealed she made a call to the Attending Physician and left a voicemail message to request a call back. She called the DON and reported the medication error/overdose. The Attending Physician did not call back, and she did not make any further attempts to notify him of the medication error/overdose because it was the responsibility of LPN #2 to notify the Attending Physician and family, because LPN #2 was assigned to the care of Resident #1. RN #2 was not able to explain why the family of Resident #1 was not informed of the medication</p>	F 226	<p>Investigate them according to facility policy (copy attached). CNAs continue to make rounds every two hours to check residents for episodes of incontinence and assure that they are clean and dry. An instant inservice prepared by the social service representative, "Abuse/Neglect Reporting" for all nursing staff began 11/22/11 (copy attached) and will be completed by 12/1/11. 4. An audit (copy attached) will be completed for all allegations of abuse, neglect or misappropriation of funds. Findings will be reported monthly to the Quality Assurance Committee for their review and recommendations. 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. The Controlled Substance log used ongoing</p>	
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Event ID: 08LUM1

Facility ID: 400212

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2110 BUCHEL BANK ROAD LOUISVILLE, KY 40218
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F 225

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error/overdose when it occurred.

Continued Interview with LPN #2 on 10/20/11 revealed she was aware the Attending Physician did not call back, and RN #2 asked a couple of times during the shift if the Attending Physician had called. She did not consider calling the Attending Physician again, because Resident #1 was resting and she did not assess for any change in the condition of Resident #1.

Further interview with RN #2, on 10/20/11 at 6:45 AM, revealed she called the Attending Physician and DON to report the medication error/overdose and did not know what else she could do at that time. The next entry in the Departmental Notes, dated 10/18/11 at 4:41 AM, detailed that Resident #1 was absent of respirations, pulses, and movement, stated the time of death at 3:08 AM, and included notification of death to the Attending Physician, DON, Chaplain, Family, and Hospice.

Interview, on 10/22/11 at 9:30 AM, with the Administrator revealed she failed to identify neglect regarding the medication error/overdose of Resident #1 on 10/17/11, and said, "I can see now, that this could be considered neglect."

Interview, on 10/28/11 at 2:40 PM, with the Attending Physician revealed his definition of neglect was "Not doing what should be done" for a resident. The Attending Physician said the nurses who did not report the medication error/overdose in an attempt to seek treatment for Resident #1 were responsible for neglect of that resident.

Record review revealed the facility found the

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by nurses will be checked daily by the Unit Manager. Any discrepancies will immediately be reported to the DON and an investigation will begin; the DON will report discrepancies to the QA Committee monthly for recommendations.

Nurses and CMTs will make rounds, following those of the CNA, at least once per shift to check all residents on their team for incontinence episodes. If residents are found to be wet or soiled they will advise the CNA to provide care to the resident. Two or more such findings will require that the CNA receive corrective action as indicated for the offense.

AMENDED POC

1. The RN on duty placed a call to the attending physician at approximately 12:00am to notify him of the medication error and requested 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.

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 BUBBELL BANK ROAD LOUISVILLE, KY 40218		
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F 226	Continued From page 24 resident without respirations or a pulse on 10/18/11 at 8:08 AM. 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. 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. 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. OMT #2 worked 10/19/11 on the 3:00 PM-11:00 PM shift and was responsible for medication administration. OMT #2 administered a dose of Oxycodone solution to Resident #8 on 10/19/11 at 6:00 PM. LPN #8	F 226	The resident was assessed after the error was discovered (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 administrator and executive director were notified of the incident by the DON at approximately 9:00am on October 18, 2011 and an internal investigation was initiated immediately by the administrator. Resident #7 was found to be excessively wet during first rounds by the day shift CNA. The resident received care immediately by the day shift CNA. 2. The neglect component of the Abuse policy was violated due to the administration of two incorrect doses of medication. There were no reports of abuse to any other resident at that time (October 17 through October 29, 2011). 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.		

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Event ID: 61111

Facility ID: 100242

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F 226	<p>Continued From page 26</p> <p>worked on 10/19/11, 10/20/11, and 10/21/11 on the 7:00 AM-3:00 PM shift and was responsible for medication administration. LPN #7 worked on 10/19/11, 10/20/11, and 10/21/11 and was responsible for medication administration.</p> <p>2. Review of the facility policy for Recognizing Signs and Symptoms of Abuse/Neglect revealed the facility defined neglect as a failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness, and identified poor resident hygiene and soiled clothing as a sign of physical neglect. Further review of the facility policy for Reporting Resident Abuse revealed the Social Services Department was responsible to conduct an investigation of the alleged abuse and would notify Adult Protective Services and the state agency within twenty-four (24) hours of the occurrence of the incident.</p> <p>Record review of the employee file for CNA #9 revealed an Employee Corrective Action Form was completed on 08/03/11 and verbal counseling was provided to CNA #9 for negligent or willful acts, or conduct detrimental to resident, customer service, or facility operations, or which resulted in neglect or abuse of any resident or others. The document alleged that CNA #9 failed to change a resident's bed which was wet with urine. Further review of the employee record for CNA #9 revealed an Employee Warning Notice, dated 09/24/11 for alleged negligent or willful acts, etc., and detailed allegations of multiple residents that were left with urine soaked briefs and soiled bed linens by CNA #9, and stated the next course of discipline could be termination. An Employee Corrective Action Form, dated 10/20/11 in the employee record for CNA #9 detailed</p>	F 226	<p>No other residents were found to be affected by this deficient practice. Residents who are Incontinent of urine have the potential of being affected by this practice, all residents were checked at the time the incident was discovered and no other residents were found to be affected by this deficient practice.</p> <p>3. In order to prevent further occurrences of abuse or neglect a mandatory inservice, "Abuse and Neglect; Medical Director" (copies attached) for all nurses and CMTs was held on Friday, October 28, 2011 at 10:00 and 11:00 am and 2:00 and 3:00pm. Those staff members who were not present were contacted by telephone and received the same information (100% "attendance" was achieved on 10/28/11). Again, the presenter and telephone witness wrote the name of the staff member and both signed to verify their "attendance". At this time those persons have signed the attendance roster further verifying their participation in the inservice. 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>	
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BURCHEL BANK ROAD LOUISVILLE, KY 40218
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F 225	<p>Continued From page 28</p> <p>Multiple residents were found in urine soaked briefs and bed linens and included a recommendation to terminate CNA #9 based on the fact the employee showed no improvement in resident care since the first incident was documented on 08/03/11.</p> <p>Interview, on 10/20/11 at 10:47 AM, with the Assistant Director of Nursing (ADON) revealed that Unit Manager #2 told her about the allegations of neglect that involved CNA #9, and was told CNA #9 showed no improvement since the initial incident (08/03/11). The ADON said she discussed the failure of CNA #9 to improve with the Executive Director of the facility and was given the authority to terminate the employment of CNA #9. The ADON defined neglect as, "not taking care of the resident in the proper manner," and thought CNA #9 had neglected the residents who were found in wet briefs, and in soiled linens. The ADON said she did not consider reporting the allegations of abuse to the state agency because the Executive Director did not ask her to do so. The ADON said we did not discuss these incidents in terms of abuse or neglect, we just knew CNA #9 should be terminated.</p> <p>Interview, on 10/29/11 at 11:26, with the Executive Director revealed when the ADON told her of the allegations of neglect which involved CNA #9, she did not review the details of the allegations or the employee file. The Executive Director was not aware that the previous allegations of neglect had not been reported to the state agency, and had not been investigated by the facility. The Executive Director was not sure why the allegations of neglect were not investigated and reported by the facility, and</p>	F 225	<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>The facility policies, "Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting Resident Abuse (Includes types of abuse) and Reporting Abuse to Facility Management" are reviewed and discussed during new employee orientation and annually.</p> <p>The social service professionals have been inserviced by the administrator of their responsibility to report allegations of abuse to the OIG as well as APS and that those situations reported to the OIG also require submission of a five day follow up final report.</p> <p>All abuse allegations will be reported to the employee's immediate supervisor at the time they are discovered who will begin an investigation and report the situation to the social service representative. The social service representative will in turn report them to the administrator and provide direction for further action including contacting APS and the OIG as is appropriate per facility policy (copy attached). All abuse policies have been revised and approved by the medical</p>	

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Event ID: 01LUM1

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F 225	<p>Continued From page 27</p> <p>explained Social Services and the Administrator work through the investigations together. The Executive Director said the facility failed to follow the Abuse and Neglect Policy regarding the investigation and reporting to the state agency.</p> <p>Interview, on 10/28/11 at 3:45 PM, with the Administrator revealed employment was terminated on 10/28/11 for CNA #9 as a result of neglect documented by the facility on 08/03/11, 08/24/11, and 10/20/11. The Administrator said none of the three (3) allegations of neglect involving CNA #9 were reported to the state agency, and none of the allegations were investigated by the facility. The Administrator had received three (3) allegations of neglect from a staff member regarding CNA #9, on 10/28/11 and did not know why the incidents had not been investigated and reported to the appropriate state agencies.</p> <p>3. Review of the facility policy Reporting Abuse to Facility Management, dated August 2009, revealed 5. When an alleged or suspected case of . . . neglect; . . . is reported, . . . the facility Administrator, or designee, will immediately (within twenty-four (24) hours of the alleged incident) notify the following persons or agencies of such incident: a. The State licensing/certification agency (state agency) responsible for surveying/licensing the facility (state agency). Review of the facility policy Abuse Investigations, dated August 2009, revealed #16, the Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the Office of Inspector General and others as may be</p>	F 225	<p>director, a mandatory inservice for ALL staff to present and discuss the new policies, "Abuse Prevention and Screening Program, Abuse Identification and Reporting and Abuse Investigation" will be given by the social service professional or the administrator on December 7 and 8 at 7:30, 2:30 and 3:30pm both days. This in-service will be taped and any nurse who cannot attend will be required to watch the video and take a post test before working. This will be monitored by the SDC, DON and ADON for compliance by all staff. The medical director was informed and also approved this inservice program and method of presentation.</p> <p>CNAs continue to make rounds every two hours to check residents for episodes of incontinence and assure that they are clean and dry. An instant inservice, "Abuse/Neglect Reporting", (copy attached) prepared by the social service representative for all nursing staff began on 11/22/11 and was completed on 12/1/11.</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 at the time of the occurrence.</p>	

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Event ID: BILU11

Facility ID: 100242

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 226	<p>Continued From page 28</p> <p>required by state or local laws, within five (5) working days of the reported incident.</p> <p>Review of the facility investigation of the allegation of neglect regarding Resident #7, revealed the initial report to the state agency was received on 09/12/11 and the five (5) day follow-up report to the state agency was received on 09/21/11. Interview with the Social Worker, who reported the incident to the state agency, on 10/27/11 at 3:00 PM, revealed she was not familiar with the facility policy regarding reporting neglect to the state agency. Telephone interview with the Acting Director of Nursing (DON, at the time of the incident) on 10/27/11 at 3:20 PM revealed she was familiar with the facility policy regarding reporting to the state agency but she stated she was busy conducting the investigation and delegated the responsibility of making the appropriate calls to the Social Worker.</p> <p>Further interview with the Social Worker, on 10/27/11 at 3:20 PM, revealed she called the report on the day she was asked to call and did not realize the report was late. She stated she had only been asked to call one (1) report to the state agency in the previous three (3) years and she was unaware of the facility policy regarding reporting. She further stated she was unaware of the need for a five (5) day follow-up report.</p> <p>Continued telephone interview with the Acting DON, on 10/27/11 at 3:20 PM, revealed she was unaware the allegation of neglect was not reported initially to the state agency within twenty-four (24) hours of the incident and she was also unaware the five (5) day report was not made to the state agency in a timely manner.</p>	F 226	<p>The allegation will be discussed with the administrator throughout the investigative process as well as the final outcome. The report will be submitted to the QA&A Committee monthly beginning December 14, 2011 for their review and recommendations. This audit form has been revised (copy attached) to include notification of the medical director. Any non compliance during the total process will be addressed immediately by the DON with the person(s) involved. Nurses and CMTs will make rounds following those of the CNAs, at least once per shift to check all residents on their team for episodes of incontinence. The attached audit tool will be used to record findings that will be submitted to the QA&A Committee monthly for their review and comment. If residents are found to be wet or soiled they will advise the CNA to provide care to the resident. Two or more such findings will require notification of the DON who will provide corrective action per facility policy.</p> <p>AMENDED POC (2)</p> <p>3. The abuse policies, "Preventing Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting Resident Abuse, Reporting Abuse to</p>	
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Event ID: 06LU11

Facility ID: 100242

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OMB NO. 0938-0391

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 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 214 BUECHEL BANK ROAD LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG F 226	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 226	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued From page 29</p> <p>Interview with the Administrator, on 10/27/11 at 8:46 PM, revealed cases of neglect should be reported to the state agency within twenty-four (24) hours of an incident of neglect and a five (5) day follow-up report of the facility's investigation results must be sent to the state agency. She stated she did not know why the reports to the state agency regarding the allegation of neglect of 09/08/11 were not reported timely.</p> <p>Review of the allegation of compliance, dated 10/28/11, and interview with the Administrator on 10/29/11 at 8:00 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. Staff received mandatory Abuse and Neglect Training on 10/28/11, and the facility provided documentation of the content which included emphasis on identification and prevention of neglect, and staff responsibility to report neglect. The facility provided documentation of 100% staff attendance on 10/28/11. 2. Interview with six (6) staff members demonstrated staff understanding of Abuse and Neglect education provided by the facility on 10/28/11. <p>Immediate Jeopardy was verified to be removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 488.13 Resident Behaviors, scope and severity at a "D", while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness</p>		<p>Facility Management, Investigating Incidents of Theft and/or Misappropriation of Resident Property, Investigating Unexplained Injuries, Reporting Suspected Cases and/or Incidents of Rape, Protection of Residents During Abuse Investigations, Reporting Abuse to State Agencies and Other Entities/Individuals, Staff Responsible for Coordinating/Implementing Abuse Prevention Program Policies and Procedures, Abuse Investigations, Abuse and Neglect - Clinical Protocol and Abuse Prevention Program" were consolidated into three policies, "Abuse Prevention and Screening Program, Abuse Identification and Reporting, and Abuse Investigations" for purposes of clarity, ease of use and to better coincide with the Guidance to Surveyors in the Long Term Care Survey manual. This project was completed on November 4, 2011 by the Home Office Clinical Liaison staff member with input from the social service professional and administrator with final approval by the medical director. The content was not changed, however, a six mandatory inservice session were presented by the</p>	

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social service professional on November 7 and 8. The inservice was taped and any staff who could not attend the original inservice were required to watch the tape and take a post test. This will be monitored by the SDC for all staff. Preventing, recognizing and reporting were emphasized as well as taking action according to the policies. CNAs continue the practice of making incontinence rounds every two hours to assure that residents are clean and dry.

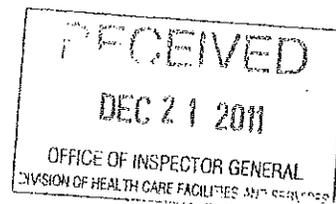
4. An audit tool, "Abuse Audit", was developed by the MDS Coordinator from the Home Office as recommended by the QA&A Committee at their October 24th meeting that included the medical director where the U was discussed in terms of monitoring systems to prevent recurrence. This tool was implemented December 1 and specifically will monitor proper notification of all necessary persons of abuse allegations. The form was revised 12/11 to include notification of the medical director. The form will be completed by the social service representative and submitted to the QA&A Committee monthly beginning with the December 2011 meeting. The SS representative and the administrator will discuss each allegation at the time it is reported and continue to have discussions throughout the investigation process as well as the final outcome. Timely reporting to proper authorities will be discussed at the onset. The social service representative will notify the appropriate department head of any non compliance during the total process, they will be address the issue immediately with involved person(s) and the corrective action process will begin.

The Resident Rounds audit tool was developed at the request of the administrator by the home office MDS Coordinator to be used by nurses and CMTs once each shift to make rounds

following those of the CNAs for all residents on each unit to determine if they are clean and dry. The tool was approved by the administrator and the medical director. The DON discussed the form and the process with the nurses and CMTs and initiated this audit on November 7. The nurses will document their findings on the form. If the resident is found to be wet or soiled the CNA will provide care to the resident; if there are two or more such findings the DON will be notified by the nurse either in person or, in the evening and night, by written message. The DON will begin the corrective action process per facility policy. These findings will be reviewed weekly by the administrator, submitted to the QA&A Committee monthly for their review and recommendations.

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



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 0 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 BUREAU BL, BANK ROAD LOUISVILLE, KY 40210	
(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 225	Continued From page 30	F 226		
F 281 68-J	<p>of staff education, utilization of tools developed and revisions to policies and procedures.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy, and review of the Kentucky Board of Nursing Advisory Opinion and Hospice Agreement, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one (1) of thirteen (13) sampled residents. The facility failed to immediately notify the physician and family of two significant medication errors related to Resident #1 on 10/17/11. The facility failed to assess and monitor Resident #1's vital signs after identifying they had administered two narcotic overdoses. These failures prevented the resident from receiving emergency medical treatment to reverse the effects of the narcotic overdoses. Resident #1 expired on 10/18/11 at 3:06 AM. The facility's failure to assess, monitor and notify the physician of the overdose placed 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 to be 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</p>	F 281	<p>1. The LPN who administered the wrong dose of medication was unsure of the amount to be administered and approached a RN on the unit who gave her incorrect information. 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. The LPN admitted the medication error but failed to complete a medication error report in a timely manner.</p> <p>2. Any of the residents who were subjected to abuse or neglect had the potential to be affected by this deficient practice. However, no other residents 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</p>	12-1-11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 108137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/29/2011
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 281	<p>Continued From page 31</p> <p>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 Kentucky Board of Nursing, Advisory Opinion Statement: Components of Licensed Practical Nursing Practice (revised 3/2011), revealed the LPN (Licensed Practical Nurse) is responsible with regard to medication administration to intervene when emergency care was required as a result of drug therapy. The LPN is also responsible to report and record significant information to include directing communication to the appropriate persons consistent with established policies, procedures, practices, and channels of communication in a timely manner consistent with the client's need for care and the LPN is responsible to determine if further communication was indicated.</p> <p>Review of the Hospice/Nursing Facility Agreement (version: 11-08) revealed item number three (3), section d, stated: The facility shall immediately inform Hospice of any changes in a patient's condition which includes: a significant change in physical, mental, social, or emotional status, clinical complications that suggest a need to change the Plan of Care, or a need to transfer from the facility, or the death of a resident.</p> <p>Review of the facility's policy for Change in a</p>	F 281	<p>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 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>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</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 BUCHEL BANK ROAD LOUISVILLE, KY 40218	
OSID 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)	(X4) COMPLETION DATE
F 281	<p>Continued From page 32</p> <p>Resident's Condition or Status revealed the Attending Physician is to be notified by the Charge Nurse when the need to alter the resident's medical treatment is identified, a need to transfer the resident to a hospital/treatment center was determined, or when the resident was involved in an accident or incident. The policy further stated the Charge Nurse was responsible to notify the resident's family when the resident is involved in an accident or incident, or when the need to transfer the resident to a hospital/treatment center is determined. The policy stated the Charge Nurse is responsible to record information in the resident's medical record relative to changes in the resident's medical condition.</p> <p>Review of the facility's policy for Identifying and Managing Medication Errors and Adverse Consequences revealed the facility is responsible to report medication errors with adverse clinical consequences to the resident's Attending Physician immediately and document appropriately detailed accounts of any incidents on an appropriate report form.</p> <p>Interview, on 10/22/11 at 9:30 AM, with the Administrator revealed staff should have continued efforts to contact the Attending Physician, and should have called the DON again if they were not able to reach the Attending Physician. The Administrator said the staff have reported it was difficult to receive a call back from the Attending Physician, and the staff should know when he could not be reached by phone, the Medical Director should be consulted.</p> <p>Review of the clinical record for Resident #1</p>	F 281	<p>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> <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. The remaining staff members received this same information at where/when? 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 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</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 0 10/20/2011
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2418 BUECHEL BANK ROAD LOUISVILLE, KY 40219
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F 281	<p>Continued From page 33</p> <p>revealed an admission date of 04/12/11 and a readmission date of 10/13/11 with diagnoses: Altered Mental Status, Chronic Renal Disease, and Right Femoral Neck Fracture (hip fracture). Hospice care was initiated on 10/14/11.</p> <p>Record review of the narcotic administration record for Resident #1, revealed Resident #1 received Oxyfast (Morphine solution) 2.5 milliliters (mls), rather than 0.125 mls as ordered by the physician for two (2) separate doses at 4:00 PM and 8:00 PM on 10/17/11. Each medication error resulted in an overdose to Resident #1, who received fifty (50) milligrams rather than two and one-half milligrams (2.5 mgs) in each dose.</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 initiate the medication error report, notify the Attending Physician or the family and did not document in the medical record.</p> <p>Interview, on 10/20/11 at 11:30 AM, with LPN #2 revealed she did not call the Attending Physician again, because she did not observe any change in the status of Resident #1 until he expired. LPN #2 said RN #2 was responsible for physician notification because she made the first call, and said RN #2 never asked her to call the Attending Physician again. LPN #2 did not document the assessments or vital signs for Resident #1, and stated she could have made repeated calls to the Attending Physician, the Director of Nursing (DON), or placed a call to Hospice.</p>	F 281	<p>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>"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. The facility</p>	

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Facility ID: 100242

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X4) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X6) DATE SURVEY COMPLETED C 10/28/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 RUECHEL BANK ROAD LOUISVILLE, KY 40210		
(X4) ID PREFIX TAG F 281	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 281	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE
	<p>Continued From page 34 . Interview, on 10/20/11 at 11:40 AM, with RN #2 revealed she made a call to the Attending Physician and left a voicemail message to request a call back. She called the DON and reported the medication error/overdose. She knew Resident #1 needed emergency treatment, and was aware of treatment the Attending Physician could use to reverse the medication overdose. The Attending Physician did not call back, and she did not make any further attempts to notify him of the medication error/overdose. RN #2 was not able to explain why the family of Resident #1 was not informed of the medication error/overdose when it occurred.</p> <p>Continued interview with LPN #2 on 10/20/11 revealed she did not consider calling the Attending Physician again, because Resident #1 was resting and she did not assess for any change in the condition of Resident #1. LPN #2 stated the overdose created an emergency situation for Resident #1, and thought the resident should have received treatment.</p> <p>Record review of the facility's Departmental Notes dated 10/18/11, revealed one (1) set of vital signs were recorded for Resident #1 at 12:28 AM, by CNA #1. The Departmental Notes dated 12/18/11 at 4:41 AM detailed a late entry by RN #2 to pronounce the death of Resident #1, a note at 4:52 AM when the funeral home arrived to transport the body, an entry by LPN #3 at 10:44 AM that indicated a medication error occurred on 10/17/11, and an entry by Unit Manager (UM) #1 that detailed an attempt to contact the family. The facility could provide no documented evidence of further attempts to contact the attending</p>		<p>policies, "Preventing Resident Abuse, Recognizing Signs and Symptoms of Abuse/Neglect, Reporting Resident Abuse (Includes types of abuse) and Reporting Abuse to Facility Management" are reviewed and discussed during new employee orientation and annually. 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. 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>A mandatory 2 hour basic management session (agenda attached) will be provided for all nurses and CMTs by the DON/ADON/Administrator on 11/29/11 and 12/1/11 at 7:30 - 9:30am, 1:00 - 3:00pm and 3:30-5:30pm each day.</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 reported</p>		

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Event ID: 061111

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 0 10/28/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUCHELL 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 281	<p>Continued From page 26</p> <p>physician or the medical director in order to seek emergency medical treatment or that the facility monitored through nursing assessment routinely after the overdose.</p> <p>Interview, on 10/20/11 at 10:20 AM, with the Administrator revealed a medication error occurred on 10/17/11, when LPN #8 gave two (2) incorrect doses of Oxyfast to Resident #1 which resulted in an overdose of 60 mgs rather than 2.6 mgs as ordered for both doses. The Administrator said the Attending Physician was not notified until 10/18/11 at 8:50 AM while he was in the facility making rounds. The Administrator said the facility did not attempt to notify the family of the significant medication error until 10/18/11.</p> <p>Interview, on 10/21/11 at 9:15 AM, with the Medical Director revealed the nurses who were assigned to the care of Resident #1 had a responsibility to continue efforts for notification of the Attending Physician because action could have been taken to reverse the medication error/overdose. The Medical Director said if the staff was unable to contact the Attending Physician, they could have called him, because that never should have happened.</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> <p>1. Mandatory staff in-services were provided to all staff responsible for medication administration on 10/18/11, and the facility provided</p>	F 281	<p>monthly to the Quality Assurance Committee for their review and recommendations.</p> <p>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. 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.</p>	

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Facility ID: 100242

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2118 RUECHEL BANK ROAD LOUISVILLE, KY 40218
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F 281	Continued From page 36 documentation of the content which included 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 effective 10/28/11. 3. The facility implemented change to the facility policy for Identifying and Managing Medication Errors and Adverse Consequences to direct staff to report medication errors with potential adverse clinical consequences to the Attending Physician immediately (revision date, 10/20/11). 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. 4. The facility implemented change to the facility policy for Change in a Resident's Condition or Status to direct staff to notify the DON if the Attending Physician cannot be reached in thirty (30) minutes (revision date, 10/20/11). The policy stated the DON and/or the on call nurse was responsible for notification of the Medical Director to request guidance. The policy included detailed 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.	F 281	AMENDED POC 1. The LPN who administered the wrong dose of medication was unsure of the amount to be administered and approached a LPN, desk nurse, on the unit for advice, this LPN gave her wrong information. The RN on duty placed a call to the attending physician at approximately 12:00am to notify him of the med error and requested 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. The LPN admitted she had made an error but failed to complete a medication error report in a timely manner. 2. The medication orders and MARs of all residents receiving high risk medications/dosages were reviewed to ensure the correct dosage was being administered as ordered. Orders and medication labels were reviewed for clarity and consistency, three of 180 were changed to provide clarity and consistency to avoid any confusion that	12/9/11

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Facility ID: 160242

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could potentially exist. Controlled substance signature sheets were reviewed for accuracy of dosages used. No other residents were determined to be at risk from this deficient practice.

3. As part of the professional standards of clinical practice the LPN who administered the incorrect medication dosage was immediately suspended and ultimately terminated on 10/24/11. During the investigation it was learned that this LPN had approached a second LPN for advice re: the correct dosage to be administered. He provided inaccurate information and was suspended on 10/20/11 (he did not work from the time of the incident until suspension) and likewise terminated on 10/24/11. Both were reported to the Kentucky Board of Nursing on 10/24/11.

Mandatory inservices were provided for all nurses and CMTs on 10/18/11 including the "Five Rights of Medication Administration" and calculation of small dosages of medication; for all staff re: "Care of Hospitus Residents" and medication administration between 10/21 and 10/24/11. A post test was administered and staff could not work unless/until they achieved 100% on the test, this was accomplished for all effective 10/28/11. The policies, "Identifying and Managing Medication Errors and Adverse Consequences" and "Change in a Resident's Condition or Status" (copies attached with changes highlighted) were reviewed and revised by the administrator, DON and ADON and approved by the medical director. They were then inserviced to staff at mandatory inservices provided between 10/22 and 10/25/11.

Telephone inservices were conducted for those employees who absolutely could not be present due to other jobs, school, FMLA, etc. A presenter and witness were present in the facility during the entire process. The staff members name was written on the

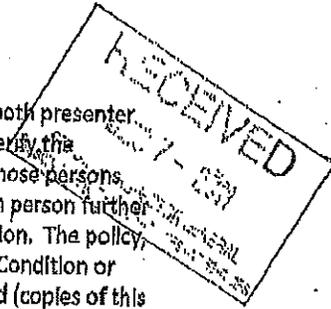
attendance roster and both presenter and witness signed to verify the inservice. At this time those persons have signed the roster in person further verifying their participation. The policy, "Change in a Resident's Condition or Status" was again revised (copies of this revision are also attached) with approval by the medical director. These changes will be addressed in a mandatory in-service for all nurses to be held December 7 and 8 at 7:30am, 2:30pm and 3:30pm. This in-service will be taped and any nurse who cannot attend will be required to watch the video and take a post test before working. This will be monitored by the SDC, DON and ADON for compliance by all nurses. These policies will receive increased emphasis during new employee orientation for all nurses. A checklist tool (copy attached) has been developed for nurses to use to ensure they have accomplished necessary tasks related to each change in resident's condition.

A mandatory 2 hour basic management training (flyer and agenda attached) was conducted by the DON for all nurses and CMTs on November 29 and December 1, 2011 at 7:30 am, 1:00 and 3:30pm each day.

These were all done in the interest of improving the standards of clinical practice of those who work in the facility.

A checklist tool (copy attached) has been developed to remind nurses of all notifications to be made when there is a change in resident's condition.

4. An audit tool, "Significant Change of Condition Notification" (copy attached) has been developed for the DON to use to monitor calls weekly made to the family members when there is a significant change. Non compliance by a nurse will result in counseling by the DON as a first step. Findings of this audit will be submitted to the QA&A Committee monthly for their review and recommendations. This data will first be reviewed at the January 2012



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An audit tool, "Physician Call Log" (copy attached) was developed with input of the medical director and the QA&A Committee. This was initiated on October 26, 2011 and determines timeliness of placement of calls to the physician and their response time as well as directions to the nurse if the call is not returned in a timely manner. This Log was again revised (copy attached) and approved by the medical director. The QA&A Committee reviewed the data for the remaining days of October re: the Physician Call Log at their November 17, 2011 meeting. Data for the entire month of November will be reviewed at the December 14, 2011. The DON will review this each morning Monday through Friday; it will also be reviewed at the monthly QA&A meetings. Non-compliance by the physician will be reported immediately to the medical director. If there is non-compliance by a nurse the corrective action process will begin. The administrator chairs the QA&A Committee and reviews all data collected prior to each meeting and participates in the determination of the action to be taken as a result of the findings submitted.

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AMENDED POC (2)

F 281 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 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

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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.

4. 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.

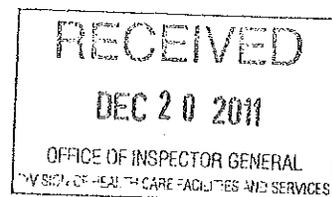
An audit tool, "Physician Call Log" was developed as a result of discussion at the October 24, 2011 Quality

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Assessment and Assurance Committee (QA&A). This will be used by the nurses each time they place a call to the physician to determine the timeliness of their return call. The ADON and DON instructed the nurses re: use of this tool and its' purpose. This audit was initiated on October 26, 2011. There was 100% compliance for the balance of October. The tool was revised at the suggestion of the nurses to include a column for the nurse who initiated the call to sign making it easier for follow up when necessary. The November data was discussed at the December 12 QA&A meeting with 84% overall compliance, nursing 77% (failed to document return call times) and 96% physician compliance. Failure to conduct the audit properly has been discussed with the ADON by the administrator and staff by the ADON. The ADON will be monitoring the completion of this audit daily on each of the two nursing units until such time as compliance with completion by nursing is achieved. The administrator will randomly review the active audit twice weekly ongoing. Following discussion of this audit at the QA&A meeting on December 12 it was decided that nurses will batch certain types of calls (normal lab results unless physician gives instructions to be called, non injury falls and skin tears. The DON will contact each physician re: the best time of day to call them with this information. The results of this audit will be submitted monthly to QA&A for their review and recommendations.

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



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F 281	Continued From page 37 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 281			
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to provide care in accordance with the resident plan of care for one (1) of thirteen (13) sampled residents. The facility admitted Resident #1 into hospice care on 10/14/11 with a physician order dated 10/14/11 for Oxyfast (Morphine solution) 20 (twenty) milligrams per milliliter (mg/ml); give 2.5 mg every four (4) hours routine and every one (1) hour for shortness of breath.	F 282	1. The LPN who administered the wrong dose of medication was unsure of the amount to be administered and approached a RN on the unit who gave her incorrect information. 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.	12-1-11	

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F 282	<p>Continued From page 38</p> <p>The facility failed to follow the plan care that directed staff to administer medications according to physician's orders and observe the resident for adverse side effects, then document and report to the physician. Resident #1 expired on 10/18/11 at 3:06 AM. The facility's failure to follow the plan of care placed 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 to be 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.</p> <p>The findings include:</p> <p>Record review of the Plan of Care for Resident #1, revealed a care plan dated 04/25/11, with a goal: The resident will have no injury related to medication usage/side effects, and included a nursing intervention which directed staff to administer medications as ordered by the physician and observe the resident for adverse side effects, then document and report to the physician. The Initial Needs Care Plan for Resident #1, dated 10/13/11, addressed Pain for Resident #1 and stated a goal: Resident will be comfortable with adequate pain control, and</p>	F 282	<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 Resident #5 read, "Lorazepam Intensoil 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/</p>	

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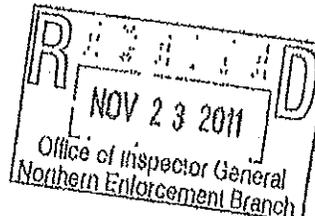
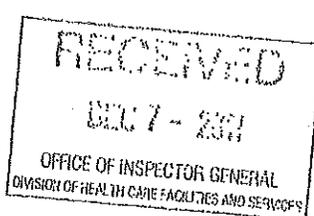
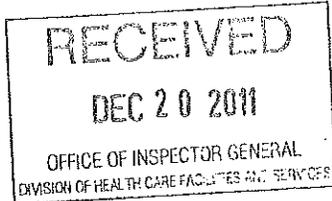
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F 282	<p>Continued From page 39</p> <p>Included a nursing intervention to assess for pain and administer pain medication as ordered by the physician.</p> <p>Record review of the Controlled Drug Record for Resident #1 revealed LPN #3 administered 2.6 ml (50 mg or twenty times the ordered dose) of Oxyfast solution on 10/17/11 at 4:00 PM and 8:00 PM which resulted in a medication error/overdose of Resident #1.</p> <p>Record review of the Departmental Notes for Resident #1 on 10/17/11 and 10/18/11 did not reveal documentation of a physical assessment of Resident #1 or attempts of the staff to notify the Attending Physician of the medication error/overdose that occurred on 10/17/11.</p> <p>Interview, on 10/20/11 at 11:40 AM, with RN #2 revealed she made a call to the Attending Physician on 10/18/11 to report the medication error/overdose given to Resident #1. RN #2 said the Attending Physician did not return the call. RN #2 said she made another call to the Attending Physician on 10/18/11, and reported the death of Resident #1 at 4:00 AM. However, there was no documented evidence to validate the physician's contact regarding the overdose.</p> <p>Interview, on 10/22/11 at 11:35 AM, with LPN #3, revealed she was uncertain of the correct volume of Oxyfast to administer to Resident #1 on 10/17/11. LPN #3 stated when she looked at the Oxyfast order and label on the medication, she intended to give 2.6 ml, but was not sure how to administer the dose with the syringes provided by Pharmacy. LPN #3 conferred with LPN #1 (Charge Nurse) about the correct volume to</p>	F 282	<p>sl) every hour prn for SOA". (Refer to attachment).</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 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 revised policies, "Charting and Documentation" "Death of a Resident", "Identifying and Managing Medication Errors and</p>	



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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUCHEL BANK ROAD LOUISVILLE, KY 40218		
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F 282	<p>Continued From page 40</p> <p>administer, and was told the correct dose was 2.6 ml. LPN #3 realized the medication error/overdose during the narcotic count on 10/17/11 between 11:00 PM and 12:00 AM, and said she knew the medication error/overdose should be reported to the Attending Physician, but did not know who was responsible for notification of the Attending Physician. LPN #3 said she did not make any attempts to report the medication error/overdose to the Attending Physician because she "was stressed," and needed to go home.</p> <p>Interview, on 10/21/11 at 9:20 AM, with Unit Manager #1 (UM) revealed LPN #3 was responsible to administer the dose of Oxyfast as ordered by the Attending Physician, and said LPN #3 should have consulted Pharmacy as a resource to ensure the volume of medication administered was correct. UM #1 said LPN #3 was responsible to notify the Attending Physician of the medication error/overdose.</p> <p>Interview, on 10/22/11 at 5:00 PM, with the Administrator revealed that staff could contact the Pharmacy with questions regarding medication dosing. Further interview, on 10/28/11 at 8:50 AM, with the Administrator revealed RN #2 and LPN #2 should have continued efforts to notify the Attending Physician of the medication error/overdose given to Resident #1. The Administrator said LPN #3 should have documented physical assessment and vital signs for Resident #1.</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</p>	F 282	<p>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>" 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</p>		

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

PRINTED: 11/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 10/29/2011
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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 282	<p>Continued From page 41</p> <p>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 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 effective 10/28/11. 3. The facility implemented change to the facility policy for Identifying and Managing Medication Errors and Adverse Consequences to direct staff to report medication errors with potential adverse clinical consequences to the Attending Physician immediately (revision date, 10/2011). The facility provided documentation of 100% compliance with staff education to the policy change; staff training began on 10/22/11 and concluded on 10/25/11. 4. The facility implemented change to the facility policy for Change in a Resident's Condition or Status to direct staff to notify the DON if the Attending Physician cannot be reached in thirty (30) minutes (revision date, 10/2011). The policy stated the DON and/or the on call nurse was responsible for notification of the Medical Director to request guidance. The policy included detailed 	F 282	<p>state agencies in a timely manner.</p> <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>A mandatory 2 hour basic management session (agenda attached) will be provided for all nurses and CMTs by the DON/ADON/Administrator on 11/29/11 and 12/1/11 at 7:30 - 9:30am, 1:00 - 3:00pm and 3:30-5:30pm each day.</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 reported monthly to the Quality Assurance Committee for their review and recommendations.</p> <p>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 or ADON/SDC. Findings will be reported to the QA Committee monthly.</p>	

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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.

2. The medication orders and MARs of all residents receiving high risk medications/dosages were reviewed to ensure the correct dosage was being administered as ordered. Orders and medication labels were reviewed for clarity and consistency, three of 180 were changed to provide clarity and consistency to avoid any confusion that could potentially exist. Controlled substance signature sheets were reviewed for accuracy of dosages used. No other residents were determined to be at risk from this deficient practice.

The care plan of resident #1 was not followed, dated 4/25/11 it stated, "The resident will have no injury related to medication usage/side effects", and included a nursing intervention which directed staff to administer medications as ordered by the physician and observe the resident for adverse side effects, then document and report to the physician. The initial needs care plan addressed pain control and assessment for pain and administration of medication for pain as ordered by the physician. The nurse did not follow the care plan as medication was not administered per the order, the resident was not assessed for adverse side effects and consequently did not report same to the physician. Additionally, the staff did not document assessments or observations in the medical record, thus violating clinical standards of practice.

3. A mandatory 2 hour basic management session (agenda attached) was provided for all nurses and CMTs by the DON on 11/29/11 and 12/1/11 at 7:30 - 9:30am, 1:00 - 3:00pm and 3:30-5:30pm each day.

A mandatory inservice for nursing staff will be conducted on December 7 and 8 at which time the policies Care Plans and Care Plans - Comprehensive (copy attached, changes highlighted) revised by the MDS Coordinator, will be presented and discussed by the MDS Coordinator. She will also present additional care plan information (copy of handout and post test attached). The medical director has reviewed and approved policy changes and educational materials.

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 by the consultant pharmacist or ADON/SDC. 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 Care Plan audit tool has been revised (copy attached). This will be completed monthly by the MDS Coordinator for 20 randomly selected care plans and reviewed for the first time at the January 18, 2012 meeting. Negative findings will be addressed by the DON using the corrective action policy. Findings will be submitted to the QA&A committee for their review and recommendations beginning at their January 18, 2012 meeting. The administrator chairs this Committee and reviews all data before it is discussed with the Committee. She is also involved in the decision for actions to be taken and length of time to continue the audit.

