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

DEC 20 2011

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

DEC 7 - 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188137	OFFICE OF INSPECTOR GENERAL (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES (X3) DATE SURVEY COMPLETED 10/29/2011
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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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(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 000	<p>INITIAL COMMENTS</p> <p>AMENDED SOD 11/21/11</p> <p>An abbreviated survey was conducted 10/20 - 10/27/11 and a partial extended survey was conducted 10/27 - 10/29/11 to investigate KY17266. Complaints KY17138 and KY17296 were initiated on 10/27/11 and concluded on 10/29/11. Immediate Jeopardy (IJ) was identified on 10/21/11 and determined to exist on 10/17/11. The facility was notified of Immediate Jeopardy in 42 CFR 483.10 Resident Rights, (F167), 42 CFR 483.13 Resident Behavior, (F224, F226), 42 CFR 483.20 Resident Assessment, (F281, F282), 42 CFR 483.25 Quality of Care, (F333) and 42 CFR 483.75 Administration, (F490) on 10/21/11.</p> <p>The facility was also notified of Substandard Quality of Care on 10/21/11 in the areas of 42 CFR 483.13 Resident Behavior, (F224, F226) and 42 CFR 483.25 Quality of Care, (F333).</p> <p>The facility staff administered two dosages of Morphine (narco) to Resident #1 on 10/17/11. The facility nurse, who administered the medication inaccurately, calculated the prescribed dosage of 2.5mg, and in effect gave 50mg, 20 times the prescribed dose, twice in four (4) hours. The facility failed to notify the attending physician and family when they identified two medication errors/overdoses had occurred. The facility took no action to seek medical treatment to reverse the effects of the narcotic overdose. The facility failed to ensure staff assigned to administer medications was competent allowing three (3) out of seven (7) staff to continue to administer medications despite their failure to pass the competency testing on</p>	F 000	<p>AMMENDED POC</p> <p>Preparation and execution of this Plan of Correction does not constitute admission or agreement to any alleged deficiencies cited in this document. This Plan of Correction is prepared and executed as required under the provisions of federal and state laws.</p>	
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janet M. Shroy, Administrator 11/22/11

DEFICIENCY STATEMENT ENDING WITH AN ASTERISK (*) DENOTES A DEFICIENCY WHICH THE INSTITUTION MAY BE EXCUSED FROM CORRECTING PROVIDING IT IS DETERMINED THAT OTHER SAFEGUARDS PROVIDE SUFFICIENT PROTECTION TO THE PATIENTS. (SEE INSTRUCTIONS.) EXCEPT FOR NURSING HOMES, THE FINDINGS STATED ABOVE ARE DISCLOSEABLE 60 DAYS FOLLOWING THE DATE OF SURVEY WHETHER OR NOT A PLAN OF CORRECTION IS PROVIDED. FOR NURSING HOMES, THE ABOVE FINDINGS AND PLANS OF CORRECTION ARE DISCLOSEABLE 14 DAYS FOLLOWING THE DATE THESE DOCUMENTS ARE MADE AVAILABLE TO THE FACILITY. IF DEFICIENCIES ARE CITED, AN APPROVED PLAN OF CORRECTION IS REQUESTED TO CONTINUE PROGRAM PARTICIPATION.

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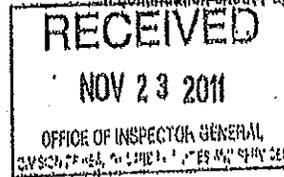
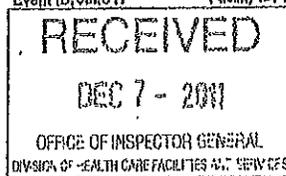
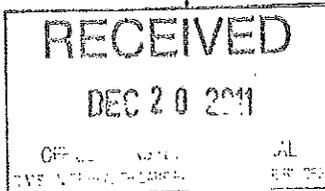
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVAY COMPLETED C 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BURGHEL BANK ROAD LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	Continued From page 1 10/18/11. The facility continued to allow staff who were not competent to administer medications. An acceptable Allegation of Compliance (AOC) was received on 10/28/11 and the Immediate Jeopardy was removed on 10/29/11 which lowered the scope and severity to a "D" at 42 CFR 483.10 Resident Rights, (F157), 42 CFR 483.13 Resident Behavior, (F224, F225), 42 CFR 483.20 Resident Assessment, (F281, F282), 42 CFR 483.25 Quality of Care, (F333) and 42 CFR 483.75 Administration, (F490) while the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures. The Division of Health Care unsubstantiated the allegation for Complaint KY17138 due to lack of sufficient evidence; however, unrelated regulatory findings were cited 42 CFR 483.13, F225, and 42 CFR 483.60, F431. The Division of Health Care unsubstantiated the allegation for Complaint KY17298 due to lack of sufficient evidence. Therefore, no regulatory violations were identified.	F 000			
F 167 SSMJ	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a	F 167	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	12-1-11	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 01LU11

Facility ID: 100242

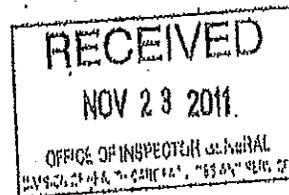
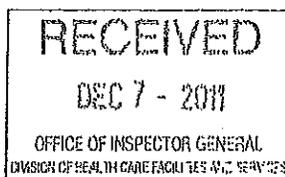
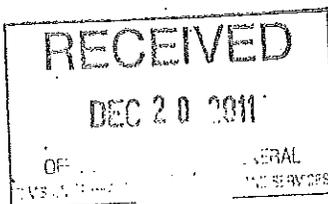
If continuation sheet Page 2 of 81



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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 G 10/29/2011
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 167	<p>Continued From page 2</p> <p>deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to consult with a resident's physician, and notify the resident's family of two medication errors which required physician intervention for a significant change in the resident's physical status including a life-threatening condition, and the need to alter treatment significantly for one (1) of the thirteen (13) sampled residents. The facility failed to follow their policies and procedures related to medication errors and significant change. The facility identified on 10/17/11 two</p>	F 167	<p>none of them documented their findings in the medical record.</p> <p>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.</p> <p>The RN also called the DON and advised her of the medication error, no action was taken.</p> <p>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.</p> <p>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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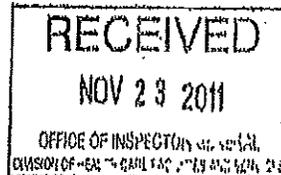
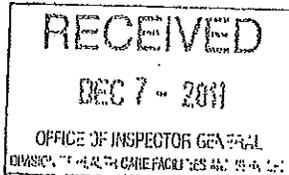
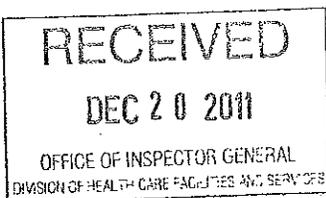
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2110 BUECHEL BANK ROAD LOUISVILLE, KY 40219.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 187	Continued From page 3 medication errors which were narcotic overdoses for Resident #1. Upon identification of the medication errors, the facility failed to notify the attending physician and/or the Medical Director promptly in order to obtain emergency medical treatment to reverse the overdose. Additionally, the facility failed to promptly notify Resident #1's family of the medication error/overdose. Facility staff found Resident #1 without respirations, pulse and movement. The resident was pronounced dead on 10/18/11 at 3:06 AM. The facility's failure to notify the resident's attending physician of the overdose placed residents receiving medications in a situation that is likely to cause serious injury, harm, impairment or death to a resident. 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 483.10 Resident Rights, with a 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. The findings include: Review of the facility's policy for Identifying and Managing Medication Errors and Adverse Consequences, with no date, revealed the facility was responsible to report clinical significant adverse medication consequences and	F 157	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/si every one hour prn for SOA". The order was changed to match the label so that they both read, "Give 0.5ml (10mg) po/si) every hour prn for SOA". (Refer to attachment" 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). 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	

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Event ID: 01LUT1

Facility ID: 100242

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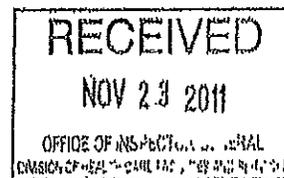
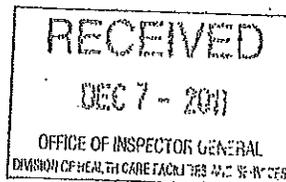
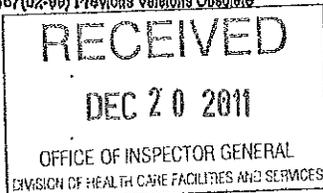
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
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F 157	<p>Continued From page 4</p> <p>medication errors with adverse clinical consequences to the resident's Attending Physician immediately.</p> <p>Review of the facility's policy for Change in a Resident's Condition or Status, dated 08/2009, revealed the facility was responsible to notify the Attending Physician and the Resident's family when: the resident was involved in any accident or incident, a significant change in the resident's condition developed, a need to alter the resident's medical treatment significantly was identified, or the need to transfer the resident to a hospital was determined.</p> <p>Interview, on 10/21/11 at 9:20 AM, with Unit Manager #1 revealed per facility policy, staff was responsible to contact the Medical Director when the Attending Physician could not be reached.</p> <p>Record review for Resident #1 revealed an admission date of 04/12/11 with diagnoses: Altered Mental Status and Right Femoral Neck Fracture (hip fracture). Resident #1 fell at the facility on 10/11/11 and was transferred to a local hospital and diagnosed with a right hip fracture. The facility readmitted the resident on 10/13/11, and Hospice care was initiated on 10/14/11. On 10/14/11 a physician order was written 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.</p> <p>Review of the facility narcotic record for Resident #1, revealed LPN #3 gave Oxyfast 2.5 ml, rather than 2.5 mg at 4:00 PM and 8:00 PM on 10/17/11. Each dose of 2.5 ml of Oxyfast elixir was the equivalent of 50 mg of morphine.</p>	F 157	<p>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 Hospice 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 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. 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</p>		

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Event ID: 811U11

Facility ID: 100242

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186437	(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 2118 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
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F 167	Continued From page 5 Review of the 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. 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 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. Interview, on 10/20/11 at 11:30 AM, with LPN #2 revealed the medication error/overdose was discovered during the narcotic count at shift change between 11:00 PM and 12:00 AM. LPN #2 said it was determined that LPN #3 made the error on the 3:00 PM-11:00 PM shift, and LPN #3 said she would complete the medication error incident report the next day and left the facility. 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. Interview, on 10/20/11 at 11:40 AM, with RN #2 revealed she was told by LPN #2 of a medication error/overdose which involved Resident #1, and 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	F 167	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. 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 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. 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. A mandatory 2 hour basic management session (agenda attached) will be		

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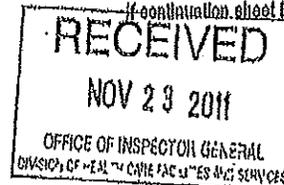
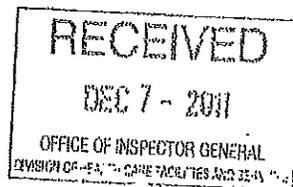
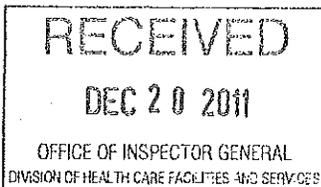
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F 157	<p>Continued From page 8</p> <p>error/overdose. She understood that Resident #1 had received a potentially lethal dose of Morphine and she also knew Resident #1 needed emergency treatment, and was aware of treatment the Attending Physician could 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 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 error/overdose when it occurred.</p> <p>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. LPN #2 stated the overdose created an emergency situation for Resident #1, and thought the resident should have received treatment. When she returned home that morning, she realized, "there were things I could have done...things I should have done." Further interview, on 10/28/11 at 8:20 AM, revealed LPN #2 said she could have called the Attending Physician or DON again, and said she could have contacted the Medical Director to report the medication error/overdose.</p> <p>Further interview with RN #2, on 10/28/11 at 6:45 AM, revealed she called the Attending Physician</p>	F 157	<p>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. In addition, 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. 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.</p>	

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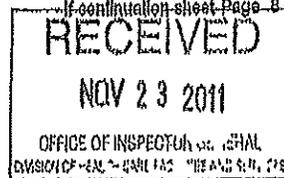
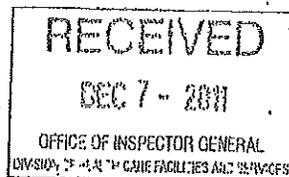
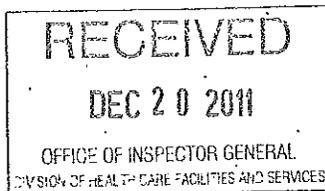
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 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 157	<p>Continued From page 7</p> <p>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.</p> <p>Interview with the Medical Director, on 10/21/11 at 9:16 AM, revealed if he had been notified, he would have sought treatment for the resident, and the overdose was potentially reversible with a drug called Narcan.</p> <p>Interview with the Attending Physician, on 10/21/11 at 9:26 AM, revealed he did not receive a call or a voice mail message from the facility staff. When he was notified of the death of the resident, he was not told of the overdose then.</p> <p>Interview with the POA, on 10/24/11 at 3:16 PM, revealed she was not notified of the overdose. She received a call on 10/18/11 at 3:16 AM that the resident had passed away; however, there was no mention of the overdose. The POA was not notified of the overdose when they arrived at the facility that morning.</p> <p>Interview, on 10/28/11 at 8:50 AM, with the Administrator and Executive Director revealed LPN #2 and RN #2 were responsible to ensure the Attending Physician and family was notified of the medication error/overdose. The Administrator said RN #2 should have continued efforts to reach the Attending Physician and should have encouraged LPN #2 to continue efforts for physician notification. The Administrator said</p>	F 157	<p>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> <p>AMENDED POC</p> <p>1. The family and the attending physician were not notified of the medication error at the time of discovery. Staff did talk with the physician at approximately 4:40 am to advise him of the death of resident #1 but did not tell him about the medication error. He was advised of the error when he made rounds on October 18, 2011 at approximately 9:15 am. The unit manager attempted to reach the resident's daughter (POA) on October 18 at 12 noon to advise her of the medication error. She left a message requesting the daughter to call her; she did not. The DON again tried to reach the POA at 5:00pm, again without success.</p>		

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 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 157	<p>Continued From page 8</p> <p>LPN #2 was "ultimately responsible" for notification of the Attending Physician.</p> <p>Interview, on 10/20/11 at 10:25 AM, with the Administrator revealed Resident #1 received two (2) overdoses of Morphine (pain medication) on 10/17/11 as a result of two (2) medication errors. The Administrator said Resident #1 expired on 10/18/11 at 3:06 AM, and the facility did not notify the Attending Physician and family when the medication error/overdose occurred. The Administrator said the Attending Physician was advised of the medication error/overdose while making rounds in the facility at 9:50 AM on 10/18/11. The Administrator said the facility left voicemail messages for the family on 10/18/11 to notify of the medication error/overdose, but the family did not return the call to the facility. The Administrator said the Jefferson County Coroner was at the facility on 10/19/11 to investigate the death of Resident #1, and notified the family of the medication error/overdose on that day.</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 10/19/11 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 100% staff compliance. 2. 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 	F 157	<p>On October 18 at 1:30pm the administrator began the process of contacting the coroner and did speak with him at 2:30pm advising him of both the medication error and the resident's death. He was on site at 3:00pm and as part of his work contacted the funeral home director and also spoke with the resident's daughter (POA) in the presence of the administrator. At that time he advised her of the medication error.</p> <p>The medical director was advised of both the medication error and the death of the resident on October 18, 2011 at 9:00am by the administrator.</p> <p>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.</p> <p>No other residents were found to be affected by this deficient practice.</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 0 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUCHEL 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)	(X6) COMPLETION DATE
F 157	<p>Continued From page 9</p> <p>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.</p> <p>3. 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 could not be reached in thirty (30) minutes (revision date, 10/2011). The policy stated the DON was responsible for notification of the Medical Director to request guidance. 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.</p> <p>4. The facility developed a process to monitor staff calls to the Attending Physician, and time of return call received which would be monitored by the DON and Administrator, implemented on 10/24/11.</p> <p>5. Record review revealed a documentation tool for staff to log calls to the Attending Physician and response time for call.</p> <p>6. 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.</p> <p>Immediate Jeopardy was verified to be removed prior to exit on 10/29/11 with remaining non-compliances at 42 CFR 483.10 Resident Rights, at a scope and severity at a "D", while the facility develops and implements a plan of</p>	F 157	<p>3. The policy, "Change in a Resident's Condition or Status" (copies attached of both the old and new, changes highlighted in the new) was reviewed and revised. Mandatory In-service to address these changes was presented by the administrator on 10/23/11 at 6:00pm, 10/24/11 at 8:00am, 2:30 and 3:30pm and by the staff development coordinator (SDC) on 10/25/11 at 11:00am, 1:40 and 2:30pm. 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. This policy was again revised (copies of this revision are also attached) with approval by the medical director. These changes will be addressed in a</p>	

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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. This same policy 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.

4. 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. 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. It will be submitted to the QA&A Committee monthly for their review and recommendations. 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 corrective action will begin with as the first step.

The significant change notification data will first be reviewed at the January 2012 QA&A Committee. This committee will make recommendations re: findings from the data as well as decisions to determine the length of time the audit is conducted.

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)

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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 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 nurse on call who, 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 second revision was made by the administrator, discussed with the DON and ADON and 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 at mandatory programs conducted by the DON on December 7 and 8. Attendance of 100% was achieved for both Inservice programs. The revised policy was initiated on December 9. These policies will receive increased

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emphasis during new employee orientation for all nurses.

4. An audit tool, "Physician Call Log" was developed as a result of discussion at the October 24, 2011 Quality 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. The audit, "Notification of Change" was developed by the administrator and discussed with the DON who was

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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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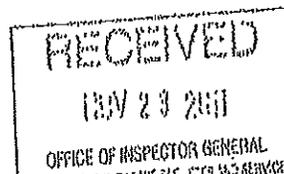
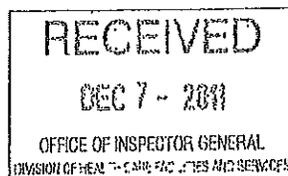
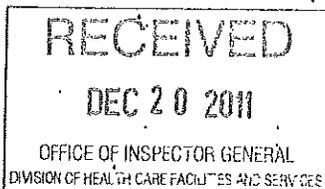
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 10	F 167		
F 224 SS#J	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to develop intervention strategies to prevent occurrences of potential resident neglect. The facility administered two (2) overdoses of Oxyfast (Morphine solution) at 4:00 PM and 8:00 PM to Resident #1 for which they identified the significant medication errors during the narcotic count between 11:00 PM and 12:00 AM on 10/17/11. The facility failed to notify the physician of the significant medication errors and prevented the resident from receiving emergency medical treatment to reverse the effects of the narcotic overdoses. Resident #1 expired on 10/18/11. On 10/18/11, the facility identified seven (7) staff responsible for administering medications out of eighteen (18) staff who could not accurately calculate medication dosages to prepare medications for administration to residents. The facility continued to utilize three (3) of the seven</p>	F 224	<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. The resident was assessed after the error was identified (8 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.</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</p>	12-1-11



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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2416 BUECHEL BANK ROAD LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG F 224	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 224	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Continued From page 11</p> <p>(7) staff to administer medications to residents. The facility failed to ensure these staff was competent in medication administration prior to allowing them to administer medications. The facility's failure to identify neglect placed residents 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 to be removed prior to exit on 10/29/11 with remaining non-compliance at 42 CFR 483.13 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 of staff education, utilization of tools developed and revisions to policies and procedures.</p> <p>The findings include:</p> <p>Review of the facility policy for the Abuse Prevention Program detailed the facility was responsible to identify occurrences and patterns of abuse and neglect, to ensure residents remain free from abuse and neglect. The policy stated the facility would develop investigative protocols and implement changes to prevent future occurrences of abuse and neglect.</p> <p>Review of the facility's policy for Identifying and Managing Medication Errors and Adverse Consequences, with no date, revealed the facility was responsible to report clinical significant adverse medication consequences and</p>		<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/si every one hour prn for SOA". The order was changed to match the label so that they both read, "Give 0.5ml (10mg) po/si every hour prn for SOA", (Refer to attachment)</p> <p>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.</p> <p>The LPN who administered the overdose and the LPN from whom she</p>		

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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 224	<p>Continued From page 12</p> <p>medication errors with adverse clinical consequences to the resident's Attending Physician immediately.</p> <p>Review of the facility's policy for Change in a Resident's Condition or Status, dated 08/2009, revealed the facility was responsible to notify the Attending Physician and the Resident's family when: the resident was involved in any accident or incident, a significant change in the resident's condition developed, a need to alter the resident's medical treatment significantly was identified, or the need to transfer the resident to a hospital was determined.</p> <p>Interview, on 10/21/11 at 9:20 AM, with Unit Manager #1 revealed per facility policy, staff was responsible to contact the Medical Director when the Attending Physician could not be reached.</p> <p>1. Record review revealed the facility readmitted Resident #1 to the facility on 10/13/11 with diagnoses of a right hip fracture and Hospice care was initiated on 10/14/11. On 10/14/11 a physician order was written 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.</p> <p>Review of the narcotic record for Resident #1, revealed LPN #3 gave Oxyfast 2.6 ml, rather than 2.5 mg at 4:00 PM and 8:00 PM on 10/17/11. Each dose of 2.6 ml of Oxyfast elixir was the equivalent of 60 mg of morphine.</p> <p>Review of the Departmental Notes, dated 10/17/11 at 9:55 PM, documented by LPN #3 revealed Resident #1 was resting in bed with</p>	F 224	<p>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> <p>3. "Care of the Hospice 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 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> <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</p>	
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Event ID: 102441 Facility ID: 100242

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 11/21/2011
FORM APPROVED
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 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 224	Continued From page 13 respirations even and unlabored. 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 3:00 PM-11:00 PM shift on 10/17/11. LPN #3 revealed she did not initiate the medication error report, notify the Attending Physician or the family and did not document in the medical record. LPN #2 Interview, on 10/20/11 at 11:30 AM, revealed the medication error/overdose was discovered during the narcotic count at shift change between 11:00 PM and 12:00 AM. LPN #2 said it was determined that LPN #3 made the error on the 3:00 PM-11:00 PM shift, and LPN #3 said she would complete the medication error incident report the next day and left the facility. 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. RN #2 interview, on 10/20/11 at 11:40 AM, revealed she was told by LPN #2 of a medication error/overdose involving Resident #1. She stated 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 understood that Resident #1 had received a potentially lethal dose of Morphine, she knew Resident #1 needed emergency treatment, and was aware of treatment the Attending Physician could use to	F 224	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. In order to prevent future occurrences of abuse or neglect a mandatory inservice, "Abuse and Neglect; Medical Director" (copies attached) for all nurses and CMTs was held 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 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 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. 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	

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Event ID: 01LU11

Facility ID: 100242

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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 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)	(X6) COMPLETION DATE
F 224	<p>Continued From page 14</p> <p>reverse the medication overdose; however, she did not make any further attempts to notify the attending physician even though he had not called back. She stated it was the responsibility of LPN #2 to notify the Attending Physician and family as 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 error/overdose when it occurred.</p> <p>Continued interview on 10/21/11 with LPN #2 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. She stated 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>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 3:06 AM, and included notification of death to the Attending Physician, DON, Chaplain, Family, and Hospice.</p> <p>Interview with the Attending Physician, on 10/21/11 at 9:25 AM, revealed he did not receive a call or a voice mail message from the facility staff. When he was notified of the death of the resident the facility did not inform him of the</p>	F 224	<p>Management are reviewed and discussed during new employee orientation and annually.</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 investigate them according to facility policy (copy attached).</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 monthly.</p> <p>Medication errors will be monitored Monday through Friday by the ADON using the attached form, the Medical</p>	

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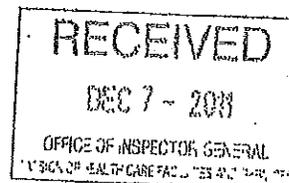
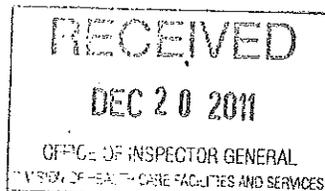
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 10/28/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2118 BUECHEL BANK ROAD LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	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 224	<p>Continued From page 15</p> <p>overdose. The Attending Physician detailed that the amount of narcotic Resident #1 received could lead to the death of the resident. On 10/28/11 at 2:40 PM, the attending Physician stated the nurse who did not report the medication error/overdose in an attempt to seek treatment for Resident #1 were responsible for neglect of the resident.</p> <p>Interview with the Medical Director, on 10/21/11 at 9:15 AM, revealed if he had been notified, he would have sought treatment for the resident, and the overdose was potentially reversible with a drug called Narcan. He further revealed that the overdose could have lead to the resident's death.</p> <p>Interview, on 10/28/11 at 8:50 AM, with the Administrator and Executive Director revealed LPN #2 and RN #2 were responsible to ensure the Attending Physician and family was notified of the medication error/overdose. The Administrator said RN #2 should have continued efforts to reach the Attending Physician and should have encouraged LPN #2 to continue efforts for physician notification. The Administrator said LPN #2 was "ultimately responsible" for notification of the Attending Physician.</p> <p>Interview, on 10/20/11 at 10:26 AM, with the Administrator revealed Resident #1 received two (2) overdoses of Morphine (pain medication) on 10/17/11 as a result of two (2) medication errors. The Administrator said Resident #1 expired on 10/18/11 at 8:08 AM, and the facility did not notify the Attending Physician and family when the medication error/overdose occurred. The Administrator said the Attending Physician was advised of the medication error/overdose while</p>	F 224	<p>Director will review the findings weekly during rounds for 9 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.</p> <p>AMENDED POC</p> <p>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.</p> <p>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</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 10/29/2011
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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 224	<p>Continued From page 16 making rounds in the facility at 9:50 AM on 10/18/11.</p> <p>2. 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 were assigned and performed the duty of medication administration for 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 Oxyfast solution to Resident #6 on 10/19/11 at 8:00 PM. LPN #8 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>Interview, on 10/21/11 at 4:10 PM, with the Administrator revealed she considered the medication error to be significant and said that is why she directed the DON (Director of Nursing) to call OIG (Office of the Inspector General). The Administrator stated she did not recognize the medication error/overdose as a case of neglect in regard to Resident #1.</p> <p>Interview, on 10/21/11 at 4:20 PM, with the Executive Director revealed the Administrator was trained to identify and report abuse and neglect and stated, "We recognized the potential for neglect with this medication error."</p> <p>Interview, on 10/22/11 at 9:30 AM, with the</p>	F 224	<p>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.</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> <p>The administrator has full understanding of her error in not recognizing this neglect and fully</p>	
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Event ID: 611111

Facility ID: 100242

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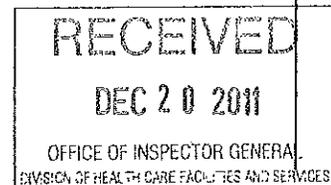
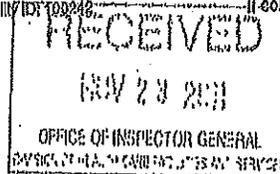
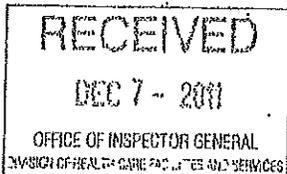
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATA SURVEY COMPLETED G 10/29/2011
NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUCHEL 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 224	<p>Continued From page 17</p> <p>Administrator revealed the medication error/overdose given to Resident #1, "could be considered neglect." The Administrator stated, "neglect was a failure to do something for someone." The Administrator said, "I did not take the next step to identify this as neglect." These failures to identify this as neglect prevented the facility from implementing corrective measures to prevent further recurrence. Thus the facility continued to allow nursing staff who were identified as incompetent in medication administration to administer medications to the residents of the facility.</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. 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 483.13 Resident Behaviors, scope and severity at a "D", while the facility develops and implements a plan of</p>	F 224	<p>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>All abuse allegations will be reported to the social service representative in a timely manner who will in turn report them to the administrator and APS and thoroughly investigate them per facility policy (copy attached).</p> <p>All abuse policies have been revised and approved by the medical 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 inservice 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</p>	

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Event ID: 41.LU11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 196197	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/28/2011
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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 224	<p>Continued From page 17</p> <p>Administrator revealed the medication error/overdose given to Resident #1, "could be considered neglect." The Administrator stated, "neglect was a failure to do something for someone." The Administrator said, "I did not take the next step to identify this as neglect." These failures to identify this as neglect prevented the facility from implementing corrective measures to prevent further recurrence. Thus the facility continued to allow nursing staff who were identified as incompetent in medication administration to administer medications to the residents of the facility.</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. 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 483.13 Resident Behaviors, scope and severity at a "D", while the facility develops and implements a plan of</p>	F 224	<p>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>All abuse allegations will be reported to the social service representative in a timely manner who will in turn report them to the administrator and APS and thoroughly investigate them per facility policy (copy attached).</p> <p>All abuse policies have been revised and approved by the medical 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 inservice 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</p>	
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Event ID: 011111

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director was informed and also approved this inservice program and method of presentation.

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. 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.

F 224 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.

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.

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.

All abuse allegations will be reported to the social service representative in a timely manner who will in turn report them to the administrator and APS and thoroughly investigate them per facility policy (copy attached).

All abuse policies have been revised and approved by the medical 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

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December 7 and 8 at 7:30, 2:30 and 3:30pm both days. This inservice will be 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.

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. 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.

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

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

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 10/20/2011
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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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(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 224	Continued From page 18 correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed and revisions to policies and procedures.	F 224		
F 226 89ca	488.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 226	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. 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 administrator and executive director were notified of the incident at approximately 9:00am on October 18, 2011 and an internal investigation was initiated immediately. The CNA was terminated 10/26/11 as a result of her negligence in resident care. 2. Any of the residents who were subjected to abuse or neglect had the	12-1-11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/29/2011
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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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(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 226	Continued From page 19 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, facility policy review, incident report review and facility investigation review, it was determined the facility failed to investigate an incident of neglect, and failed to report the results of the facility's investigation of the allegation within five (5) working days of the incident for three (3) of thirteen (13) sampled residents. The facility failed to follow their reporting abuse policy. The facility failed to report incidents of staff neglect to the state agency and investigate the potential neglect of Resident #1, when staff did not immediately notify the Attending Physician and family of two potentially life-threatening medication errors nor sought emergency medical treatment after the facility identified they had administered a narcotic overdose to Resident #1. Resident #1 expired on 10/18/11. The facility failed to report three (3) allegations of resident neglect, all of which involved CNA #9, to the state agency and failed to investigate the reports of neglect where multiple residents were found in urine soaked briefs and soiled linens. The facility failed to report an allegation of neglect regarding Resident #7 to the state agency that occurred on 09/08/11, and failed to report the facility findings within five (5) working days of the incident. The facility's failure to report incidents of staff neglect placed residents in a situation that is likely to cause injury, harm, impairment or death to a	F 226	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 were identified and 8 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/	

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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 10/20/2011
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2116 BUREAU 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 20 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 10/20/11 with remaining non-compliance at 42 CFR 483.18 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 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 Reporting Resident Abuse detailed the Social Services Department was responsible to conduct an investigation of the alleged abuse and to notify Adult Protective Services and the state agency within twenty-four (24) hours of the reported allegation. The facility policy defined neglect as: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.</p> <p>Interview, on 10/22/11 at 8:30 AM, with the Administrator revealed the state agency was notified by the facility on 10/18/11 of a medication error/overdose that occurred on 10/17/11 which involved the care of Resident #1. The Administrator said she made the decision to notify the state agency because, "this was a huge</p>	F 225	<p>s) 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 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). Residents who are incontinent of urine have the potential to be affected by this practice. However, no other residents were affected.</p> <p>3. A mandatory inservice, "Abuse and Neglect; Medical Director" (copies attached) for all nurses and CMTs was held 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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