

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

PRINTED: 06/03/2013
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 C 05/21/2013
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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS Amended 06/03/13	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to implement their policy in the areas of protection and reporting allegations of physical abuse for one (1) of three (3) sampled residents. A nurse failed to immediately remove the Certified Nursing Assistant (CNA) and immediately inform administration regarding an abuse allegation. The nurse allowed a CNA to continue to work her shift and care for other residents after Resident #1 informed the nurse he/she was afraid and was manhandled by a CNA. The findings include: Review of the facility's policy, revised November	F 226	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. It is the policy of this facility to promptly report any incident of or suspected incident of resident abuse. The way that this has been achieved for Resident #1 is by the C.N.A. was removed from providing care to Resident #1 on 5/14/13. Investigation of the incident substantiated abuse of Resident #1. The C.N.A. involved and LPN #1 were suspended from employment on 5/14/13 and their employment was terminated on 5/16/13.	5/19/13

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

TITLE

(X6) DATE

[Signature] Executive Director 6/4/13

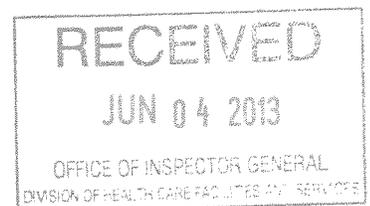
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

JUN 04 2013

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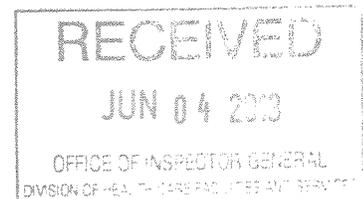
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F 226	Continued From page 1 2010, revealed the facility utilized the federal requirements under 42 CFR 483.13 to ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property was reported immediately to the Administrator of the center and other officials, in accordance with state law. The policy specific to reporting and protecting abuse reveals, employees must immediately report any suspected abuse or incidents of abuse to their immediate supervisor. The facility would protect the residents from harm by immediately reassigning the employee to duties that do not involve resident contact or would be suspended until the findings of the investigation had been reviewed by the Administrator. Interview with Resident #1, on 05/21/13 at 11:05 AM, revealed CNA #2 had provided him/her care several times on the night shift. He/she continued to state the CNA had never been kind and he/she had not relayed any information regarding CNA #2's treatment to anyone at the facility. The resident also stated being aware of when, and to whom to report allegations, incidents and or complaints. Resident #1 stated, on 05/12/13, the CNA treated him/her extremely rough while providing incontinent care. The resident stated again he/she did not notify the facility immediately regarding CNA #2's ill treatment. The resident continued to state not wanting to cause trouble with reporting the incident. However, on 05/14/13 at or around 1:00 AM, LPN #1 was informed by the resident of CNA #2's manhandling and the resident complained of pain in the right upper arm. The resident stated LPN #1 reassigned another CNA to his/her care.	F 226	How the facility will identify other residents having the potential to be affected by the same deficient practice. Because all residents receiving physical assistance are potentially affected by the cited deficiency, on 5/21/13, the social services director reviewed previous complaint and grievance files, and social service assistant performed interviews and found no other residents were affected.	5/21/13	



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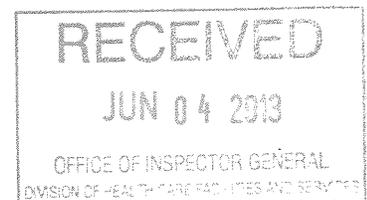
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F 226	Continued From page 2 Phone interview with LPN # 1, on 5/22/13 at 1:30 PM, revealed Resident #1 was near the nurse's desk and stated, on 5/12/13 during the night, CNA #2 was mean and manhandled her during a brief change. The LPN stated the resident identified CNA #2. He stated the resident also complained of his/her right upper arm hurting. He assessed the resident's upper arm and it revealed no marks, bruises or swelling. The LPN stated he reassigned the resident to a different CNA. During the shift the resident voiced no other concerns. However, at the end of the shift a skin assessment was performed and noted 1 x 2.7 cm diameter, medium, purple bruise on the resident's right inner calf. He did not report the incident to the on call supervisor until 7:30 AM. The LPN verbalized being trained on abuse during his orientation. He further stated based on the facility's abuse training the alleged CNA should not have continued to work with residents and administration should have been notified immediately. He stated because CNA #2 was not removed from the facility immediately any resident could have been harmed. Attempted phone interview with CNA #2, on 05/22/13 at 1:20 PM and 2:00 PM, revealed a voice message identified the CNA's first name. A message was left to contact this office, as of 05/23/13 at 1:00 PM there had been no return call from CNA #2. Interview with CNA #1, on 05/22/13 at 6:20 AM, revealed she was reassigned to Resident #1 on 05/14/13 and was unsure of the time, but stated all her first round checks were performed. The	F 226	What measures will be put into place or systemic changes made to ensure that all deficient practice will not recur. The director of nursing completed in-service training on 5/15/13-5/22/13 for all licensed nurses regarding abuse identification, facility reporting policy and state and federal requirements. The director of nursing will provide all facility staff with in-service training regarding abuse identification and reporting to be completed by 6/21/13. This training will cover the types of abuse, the expectations of identifying and reporting policies. All staff are required to complete post tests after in-service training. Any staff member scoring less than 100% on post tests will be required to complete additional training provided by the Director of Nursing and retake test until 100% score is achieved.	6/22/13	



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F 226	<p>Continued From page 3</p> <p>CNA stated after providing Resident #1 with personal care the resident slept the rest of the shift. She continued to state being trained on abuse and stated that no employee should be in direct resident's care if abuse was alleged.</p> <p>Interview with LPN #2, on 05/22/13 at 8:20 AM, revealed she had cared for Resident #1 on 05/12/13 during the night shift, the resident did not voice any concerns. During the night she was visible on the floor and made rounds during alternating hours of the CNA to ensure care was being provided.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 05/22/13 at 2:30 PM, revealed she was the supervisor on call the night of 05/12/13 and 05/13/13. She continued to state she was not made aware of the allegation of abuse until she received a call on her cell phone at 7:30 AM. She immediately notified the Director of Nursing (DON) and an investigation was started per protocol. She stated based on the policy the residents were not protected as long as the alleged abuser was in the facility caring for residents.</p> <p>Interview with the DON, on 05/22/13 at 2:40 PM, revealed staff are trained on how and when to report abuse. The facility had and on call supervisor available after hours. She stated the on call supervisor should have been notified immediately after the allegation was made and the CNA should have been removed from all resident contact.</p> <p>Interview with the Administrator, on 05/22/13 at 2:55 PM, revealed the facility failed to protect the</p>	F 226	<p>How the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>The administrator will perform weekly random interviews with 5 staff members, regarding types of abuse, identification and reporting requirements. Any deficiencies will be corrected on the spot with education/training. Once 100% compliance is reached on random interviews for four consecutive weeks, interviews will be changed to monthly. Results of in-service training post tests and Administrator random interviews will be submitted to the quality assurance committee monthly. The findings of the quality assurance program will be documented for further review or corrective action for the next six months.</p>	6/22/13	



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F 226	Continued From page 4 residents from abuse when the nurse did not remove the CNA from all resident care and the on call supervisor was not notified.	F 226			

