

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

PRINTED: 06/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/02/2015
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NAME OF PROVIDER OR SUPPLIER THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
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{F 000} INITIAL COMMENTS

{F 000}

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 06/01/15.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	<p>An Abbreviated Survey investigating KY00023137 was initiated on 04/23/15 and concluded on 04/24/15 with deficient practice cited at the highest Scope and Severity of a "D." 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</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 review and revise the Comprehensive Care Plan for one (1) of three (3) sampled residents (Resident #2).</p>	F 280	<p>1. Resident #2's Care Plan was updated by MDS nurse on 4-28-2015 to reflect inappropriate behavior toward staff and interventions to address inappropriate behaviors.</p> <p>2. An audit was completed by the Medical Records nurse/DHS/ADHS on 5-15-2015 to ensure residents, with inappropriate sexual behaviors, have current care plans with interventions to address those behaviors.</p> <p>3. MDS nurse/Charge nurses will be re-educated by Medical Records nurse/DHS/ADHS on 5-22-2015 on care plan policy procedure with an emphasis on care planning interventions.</p> <p>4. Ten percent of resident care plans will be audited by Medical Records nurse/DHS/ADHS to ensure care plans are updated to reflect any inappropriate</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Beth Blair Executive Director</i>	TITLE	(X6) DATE 5/18/15
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F 280	Continued From page 1 Resident #2 exhibited inappropriate behaviors towards staff; however, there was no documented evidence the resident's Comprehensive Care Plan was revised to address the behaviors. The findings include: Review of the facility's, "Guidelines for Care Plan Development" policy, dated June 2013, revealed care plans should be updated as resident needs changed, and would include triggers, diagnoses, risk factors and other resident care needs. Review of Resident #2's medical record revealed the facility admitted the resident on 11/20/14, with diagnoses which included Dementia with Behavioral Disturbance, Parkinsonism and Glaucoma. Review of the Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #2 as cognitively impaired. Review of Resident #2's "Behavior Monitoring Record" for January, February, March and April 2015 revealed Resident #2 exhibited behaviors to include pinching and hitting staff. Continued review of the "Behavior Monitoring Records" revealed no documented evidence of Resident #2 being inappropriate towards female staff which included touching or rubbing. Review of the Resident #2's Comprehensive Care Plan, "Individual Plan Report" revealed no documented evidence the care plan was revised/updated to include the inappropriate behaviors towards female staff. Interview with State Registered Nursing Assistant (SRNA) #1 on 04/23/15 at 2:19 PM revealed	F 280	sexual behaviors, weekly for four(4) weeks then monthly for three(3) months. The QA committee will review results of all audits. The QA committee will monitor the effectiveness and compliance and develop further plans of action as required. 5. June 1, 2015	

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F 280 Continued From page 2

although he had never observed Resident #2 acting out towards other residents, he had observed Resident #2 being inappropriate towards female staff and that was why he gave Resident #2 his/her showers.

Interview with SRNA #2 on 04/23/15 at 3:21 PM, revealed she had observed Resident #2 making inappropriate comments and gestures to female staff. SRNA #2 stated she had observed Resident #2 fondling himself/herself, and rubbing female staff members legs or butt.

Interview with SRNA #3 on 04/23/15 at 3:46 PM, revealed Resident #2 twisted the wrist of another SRNA which resulted in a sprained wrist. SRNA #3 also revealed Resident #2 had tried to kiss her before, and had made statements regarding some of the younger female SRNA's and saying he/she was "going to marry her".

Interview with Registered Nurse (RN) #2 on 04/24/15 at 1:27 PM, revealed Resident #2 had been aggressive towards her before and tried to kick her on one (1) occasion. RN #2 revealed she had not heard of any sexual behaviors until SRNA's brought it to her attention a few weeks ago that Resident #2 masturbated in his/her room some mornings. RN #2 revealed Resident #2's care plans should have been revised/updated to include his/her inappropriate behaviors with female staff if that was occurring.

Interview with the MDS Coordinator on 02/24/15 at 2:24 PM, revealed she was responsible for revising/updating care plans, and did this primarily through information gathered at the morning meeting. The MDS Coordinator revealed all orders, incidents, and change of

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F 280 Continued From page 3
condition forms were brought to the morning meeting, and nothing had been brought to morning meeting regarding Resident #2's behaviors towards female staff. Further interview revealed if she had been aware of Resident #2's behaviors towards female staff, they would have been addressed on the resident's care plan.

Interview with the Director of Nursing (DON) on 02/24/15 at 4:00 PM, revealed she had not been made aware of any previous aggressive or sexual behaviors by Resident #2 towards female staff. Per interview, had she been made aware, she would have ensured MDS was aware in order to update/revise Resident #2's care plan.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide necessary care to address all areas of specific resident behaviors for one (1) of three (3) sampled residents (Resident #2).

Resident #2 exhibited and was care planned for behaviors of Psychosis and aggression. Staff

F 280

F 309

1. Resident #2 received a psychiatric consult and was discharged from the facility on 4-27-2015.
2. Legacy staff were interviewed by the DHS/Legacy Director on 5-22-2015 to identify other residents that may have sexual behaviors and to assure their care plans reflect their current plan of care.
3. Legacy staff will be educated by LND/UC/DHS/Medical Records nurse on 5-22-2015 to report to the charge nurse any unusual events related to inappropriate resident behavior toward

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F 309: Continued From page 4

interviews revealed Resident #2 started displaying inappropriate behaviors of touching or rubbing on female staff; however, the facility failed to reassess the resident related to these sexually inappropriate behaviors and failed to revise the care plan to reflect his/her sexually inappropriate behaviors. Therefore, on 04/15/15, Resident #2 displayed inappropriate sexual behavior towards a resident from another level of care of touching the other resident on the breast two (2) different times.

The findings include:

Review of the facility's policy titled, "Guidelines for Behavior Observations", undated, revealed the purpose of the policy was to provide guidelines for the observation, monitoring and tracking of behavior episodes of residents. Continued review of the Policy revealed any new or exacerbation of an existing behavior should indicate a Social Service referral.

Review of the facility's policy titled, "Guidelines for Care Plan Development", undated, revealed the purpose of the policy was to ensure care plans were developed to communicate residents' preferences and care needs. Per the Policy, the care plan should be updated as residents' preferences and needs changed.

Record review revealed the facility admitted Resident #2 on 11/20/14, with diagnoses which included Parkinsonism and Dementia with Behavioral Disturbance. Review of the 04/15/15 Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #1 to be cognitively impaired, and to have had no behaviors. Review of the hand-written Nurse's

F 309: staff or residents so behaviors can be documented on the comprehensive care plan.

4. Ten percent of Legacy staff will be interviewed by LND/UC/DHS to identify inappropriate sexual behaviors toward staff or residents. Any residents identified with these behaviors will be audited to assure their clinical record is updated to reflect the behaviors, weekly for 4 weeks, then monthly for 3 months. The QA committee will review the results of all audits. The QA committee will monitor the effectiveness and compliance and develop further plans of action as required.

5. June 1, 2015

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F 309 Continued From page 5

Notes dated 12/08/14 through 04/17/15, revealed no documented evidence of Resident #2 displaying inappropriate behaviors towards female staff.

Review of the January, February, March and April 2015 "Behavior Monitoring Record" for Resident #2 revealed the resident was documented to have behaviors which included mood changes, anxiousness, agitation, fighting, pinching, hitting, wandering, slapping, scratching, squeezing and refusal of care. However, continued review revealed no documented evidence of Resident #2 inappropriately touching female staff or other residents.

Review of the "Psychiatric Consult" Report dated 01/09/15, revealed the Psychiatrist documented Resident #2 had behaviors of "crawling around on the floor", and could get agitated and verbally aggressive. Continued review of the 01/09/15 "Psychiatric Consult" Report revealed the Psychiatrist ordered Resident #2's Seroquel (a medication used to treat Psychosis, Schizophrenia and Bipolar Disorder) to be increased. Review of the 02/20/15 Consult Report revealed it was noted staff reported Resident #2's mood was better, but he/she had increased agitation with redirection and staff requested a "PRN" (as necessary) medication for the agitation. Continued review of the 02/20/15 Consult Report revealed the Psychiatrist increased Resident #2's Seroquel again. Review of the "Psychiatric Consult" Report dated 03/17/15, revealed Resident #2 had been waking up at night and was "very combative with staff". Further review of the 03/17/15 Consult Report revealed the Psychiatrist again increased Resident #2's Seroquel. Further review of the

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F 309	<p>Continued From page 6</p> <p>"Psychiatric Consult" Reports revealed no documented evidence the Psychiatrist was notified of any inappropriate sexual behaviors by Resident #2, such as touching female staff.</p> <p>Review of Resident #2's Comprehensive Care Plan, "Individual Plan Report" revealed the resident was care planned for moods and behaviors and was on antipsychotic and antidepressant medication related to Psychosis and aggression. Continued review of the care plan revealed the goal was for Resident #2 to have no adverse side effects of the psychotropic medication. The care plan revealed interventions which included to administer the resident's medication as ordered and observe for effectiveness and adverse side effects; notify the Physician of any adverse side effects and psychiatric (psych) consults as needed. However, further review revealed no documented evidence the care plan was revised or updated to include inappropriate behaviors by Resident #2 towards female staff.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 04/23/15 at 2:19 PM revealed he had observed Resident #2 being inappropriate towards female staff before, which included inappropriate verbalizations and inappropriate touching. He reported he gave Resident #2's showers because of the resident's inappropriate behavior towards female staff. SRNA #1 revealed he had not observed Resident #2 exhibiting the behaviors towards other residents however.</p> <p>Interview with SRNA #2 on 04/23/15 at 3:21 PM, revealed she had seen Resident #2 making inappropriate comments and gestures towards</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>female staff. Per interview, she had observed Resident #2 "fondling" himself/herself before, as well as, rubbing female staff members legs or "butts" if they turned around. She stated Resident #2 was "sometimes clearly sexually acting out".</p> <p>Interview with SRNA #3 on 04/23/15 at 3:46 PM, revealed Resident #2 sometimes got a "crush" on some of the younger female staff members, and would tell them he/she was "going to marry" them. Per interview, Resident #2 had tried to kiss her before, "I'm going to marry her." SRNA #3 also revealed Resident #2 had tried to kiss her before. SRNA #3 also revealed Resident #2 had twisted another SRNA's wrist resulting in the SRNA suffering a sprained wrist.</p> <p>Interview with SRNA #7 on 04/24/15 at 1:15 PM, revealed she had witnessed Resident #2 masturbating every morning and she allowed him/her privacy before getting the resident up out of bed. She stated however, she had not really heard of Resident #2 "sexually acting out" towards female staff.</p> <p>Interview with Registered Nurse (RN) #1 on 04/24/15 at 9:31 AM revealed she had been present on days when Resident #2 had thrown silverware and twisted the arm of an SRNA without any obvious precipitating event. RN #1 revealed she wasn't certain what the Individual Plan Report stated in regards to Resident #2's behaviors, although removing residents from a situation was one of the first things they did if a resident was acting out in any way, which was often not effective for Resident #2.</p> <p>Interview with RN #2 on 04/24/14 at 1:27 PM</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>revealed she had not observed Resident #2 exhibiting any sexual behaviors, and was not aware of any until aides brought to her attention a few weeks ago the resident was masturbating in his/her room on some mornings. RN #2 went on to reveal if a resident had inappropriate behaviors, the behaviors should be documented and the care plan updated/revised with the information.</p> <p>Review of the facility's "Long Term Care Facility Self-Reported Incident Form" dated 04/17/15, revealed Resident #2 had been observed touching the breasts of a resident from another level of care who shared the same common areas as Resident #2.</p> <p>However, further review of Resident #2's medical record revealed no documented evidence of Nurse's Notes or care plan updates/revisions related to Resident #2's inappropriate behaviors towards female staff and the resident from another level of care.</p> <p>Interview with SRNA #5 on 04/23/15 at 4:14 PM, revealed just prior to 6:30 PM on 04/15/15, she observed Resident #2 sitting on a couch in a common area next to a resident from another level of care touching the other resident's breasts. SRNA#5 revealed she reported Resident #2's behavior to Licensed Practical Nurse (LPN) #1, who went over and pulled the resident from another level of care's shirt down. Further interview revealed shortly after the incident she saw SRNA #1, who told her he had just observed Resident #2 fondling the resident from another level of care's breasts, while the two (2) residents were sitting on the couch in the common area. SRNA #5 stated she told SRNA #1 she had</p>	F 309		
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F 309	Continued From page 9 observed the same thing. Interview with LPN #1 on 04/23/15 at 4:07 PM, revealed she had been working the night of 04/15/15, and SRNA #5 had told her to go look at Resident #2 and a resident from another level of care on the couch. LPN #1 stated she went and observed Resident #2 to have his/her hand on the resident from another level of care's belly. LPN #1 stated Resident #2 pulled the resident from another level of care's shirt back down, and she (LPN #1) returned to her unit to finish passing medications. Interview, on 02/24/15 at 4:00 PM, with the Director of Nursing (DON) revealed staff had not made her aware of Resident #2 having any previous sexually inappropriate behaviors towards female staff. The DON revealed if she had been made aware she would have ensured Resident #2's behaviors were reported to MDS so the resident's care plan could be updated and revised.	F 309			