

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSESUD ROAD LEXINGTON, KY 40509
--	---

(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 INITIAL COMMENTS

A Recertification Survey was initiated on 08/12/14 and concluded on 08/15/14, with deficiencies cited at the highest Scope and Severity of an "F".

F 221 483.13(a) RIGHT TO BE FREE FROM SS=D PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's Guideline for Restraint Use, it was determined the facility failed to follow the systematic restraint application process for one (1) of fifteen (15) sampled residents (Resident #5). Observation revealed Resident #5 had a lap belt restraint; however, record review and interview revealed the facility failed to have documented evidence of a Physician's Order with the related medical condition for the restraint. Additionally there was no documented evidence of informed consent signed by the legal surrogate. Observation revealed staff failed to release the restraint as per the plan of care.

The findings include:  
Review of the facility's, "Guidelines for Restraint/Enabler Use", undated, revealed the purpose was to ensure completion of assessment and evaluation for appropriate and safe use of restraints. Review of the Guideline revealed the

F 000 Plan of Action  
The Willows at Hamburg  
Standard Survey 8/15/14

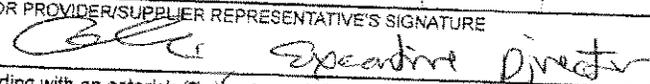
Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.

F 221 483.13 (a) Right to be free from physical restraints

Criteria 1:  
A physician's order was obtained by the Director of Health Services (DHS) on 8/14/14 for Resident #5. Resident #5 will receive a new restraint assessment with POA signature obtained by 9/21/14.

Criteria 2:  
Other residents with restraints, their clinical record was reviewed by the DHS/ADHS/Charge Nurse to assure a physicians order was obtained and a restraint assessment was completed. Any discrepancies noted will be completed prior to 9/21/14.

Criteria 3:  
Nursing staff were reeducated on the restraint policy and procedure by the DHS/ADHS/Charge Nurse with an emphasis on removing restraints during care and meals. This education was started on 9/9/14 and will be completed by 9/21/14.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 9/8/14
--	-----------------------------	---------------------

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.

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 221	<p>Continued From page 1</p> <p>facility was to obtain a Physician's Order which included the type of restraint and medical symptoms for the restraint. Further review of the Guideline revealed restraints were to be released during routine care, including supervised eating.</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident on 05/01/13, with diagnoses which included Alzheimer's Disease and Non-Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/09/14, revealed the facility assessed the resident to be severely cognitively impaired with long and short term memory impairment. Further review of the MDS revealed the facility assessed Resident #5 to have a trunk physical restraint.</p> <p>Continued review of Resident #5's medical record revealed no documented evidence of a Physician's Order and related medical justification for the use of the restraint. In addition, the record contained no documented evidence of a restraint assessment which included the risk and benefits of restraint use signed by the resident's Power of Attorney (POA). Further review of the medical record revealed the Comprehensive Care Plan included a care plan dated 03/06/14, to apply a self releasing alarming lap belt per family request due to poor safety awareness. Continued review of the care plan revealed interventions which included the restraint to be removed at mealtime and when staff was providing care.</p> <p>Interview, on 08/14/14 at 10:54 AM, with the MDS Coordinator revealed Resident #5's Velcro lap belt alarm was considered a restraint because the resident could not release the seat belt on command. The MDS Coordinator stated the restraint was requested by the family due to the</p>	F 221	<p><b>Criteria 4:</b> Residents with new restraints, their clinical record will be audited by the DHS/ADHS/Charge Nurse to assure assessment completed and physician order obtained. These audits will be completed weekly for four weeks, then monthly x 3 months. The QA committee will review results of all audits weekly for four weeks then monthly for three months for compliance. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow up actions or education for staff as indicated.</p> <p><b>Criteria 5:</b></p>	9/22/14	

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

PRINTED: 08/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 221	<p>Continued From page 2</p> <p>resident having poor safety awareness.</p> <p>Observations on 08/13/14 at 8:05 AM, and on 08/14/14 at 12:39 PM, revealed Resident #5 to be in restorative dining with a Velcro lap belt alarm in place.</p> <p>Interview, on 08/14/14 at 12:39 AM, with Certified Nurse Care Assistant (CNCA) #7 and CNCA #8 revealed they both had assisted Resident #5 with meals in the dining area before. CNCA #7 stated Resident #5 currently had the lap belt alarm on, and both CNCA #7 and #8 stated they always left the resident's lap belt on during meals.</p> <p>Interview, on 08/14/14 at 5:02 PM, with CNCA #2 revealed Resident #5 was supposed to have the Velcro lap belt alarm on at all times when up in his/her wheelchair. CNCA #2 also revealed she had assisted Resident #5 with meals in the restorative dining room leaving the Velcro lap belt alarm on the resident.</p> <p>Interview, on 08/14/14 at 4:49 PM and at 5:06 PM, with Registered Nurse (RN) #2 revealed Resident #5's Velcro lap belt alarm was a restraint and required a Physician's Order. After reviewing Resident #5's medical record which contained the Physician Orders, RN #2 stated she could not find an order for the Velcro lap belt alarm, but there was supposed to be one. Continued interview with RN #2 revealed nurses were supposed to monitor to make sure the aides followed residents' care plans; however, she stated she was unaware Resident #5's care plan had an intervention to remove the lap belt for all meals and provision of care.</p> <p>Interview with the Director of Nursing (DON).</p>	F 221		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 221	Continued From page 3 Corporate Consultant (CC), and Administrator on 08/15/14 at 9:40 AM, regarding restraint use, revealed the facility was supposed to attempt the least restrictive device. The CC revealed Resident #5 had medical symptoms, such as dementia, poor safety awareness and poor trunk control which warranted the use of the restraint. The CC stated the facility's process was to obtain a Physician's Order for restraint use which included the diagnosis, when to apply/release the restraint, but they were unable to find a Physician's Order for Resident #5's seat belt restraint. In addition, the CC stated the restraint process included a risk versus benefits informed consent signed for the use of the restraint. However, the CC reported the facility could not find the signed informed consent document which was supposed to have been signed by Resident #5's POA. Further interview revealed Resident #5's care plan included releasing the seat belt during meals and staff was supposed to be knowledgeable of and follow the resident's care plan.  Interview with Resident #5's Physician, on 08/15/14 at 11:29 AM, revealed he could not say for sure he had been made aware the resident had an alarming lap belt restraint, but the resident was a high risk for falls.  Interview with the Advanced Resident Nurse Practitioner (ARNP) on 08/15/14 at 11:37 AM, revealed she could not recall when exactly she was aware or if she had given a verbal order for the alarming lap belt restraint. The ARNP revealed the resident was at risk for falls and the belt may have been an intervention.	F 221		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 280 SS=D	Continued From page 4 PARTICIPATE PLANNING CARE-REVISE CP  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.  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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's guidelines, it was determined the facility failed to ensure the Comprehensive Plan of Care was reviewed and revised after falls for one (1) of fifteen (15) sampled residents. Resident #4 had a history of falls and sustained two (2) falls on 07/28/14; however, the resident's fall risk care plan was updated with new interventions after the falls per the facility's process.  The findings include:	F 280	<b>F280 483.20 (d)(3), 483.10(k)(2) Right to participate planning care--revise CP</b>  <b>Criteria 1:</b> Resident #4 care plan was updated by DHS/ADHS/MDS Nurse on 8/14/14 to include appropriate fall preventions.  <b>Criteria 2:</b> Other residents with fall care plans were reviewed by the DHS/ADHS/MDS Nurse by 8/18/14 to assure care plans were current and contained appropriate fall preventions.  <b>Criteria 3:</b> Nurses were reeducated by the DHS/ADHS/MDS Nurse on the policy and procedure for updating care plans with an emphasis on appropriate interventions as it relates to falls. This in-service was started on 9/9/14 and will be completed on 9/21/14.  <b>Criteria 4:</b> Ten percent of residents with fall care plans will be audited by DHS/ADHS/MDS Nurse weekly x four weeks then monthly x 3 months to assure they contain current and appropriate interventions. The QA committee will review results of all audits weekly for four weeks then monthly for three months for compliance. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow up actions or education for staff as indicated.  <b>Criteria 5:</b>	9/22/14	

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 280 Continued From page 5

F 280

Review of the facility's "Falls Management Program Guidelines", revised date March 2008, revealed the facility tried to mitigate fall risk factors and implement preventive measures. The Guideline procedures included completion of an investigation of the cause and interventions to reduce the risk of a repeat episode. In addition, the procedures required the Interdiscipline Team (IDT) evaluated the thoroughness of the investigation and the appropriateness of the intervention.

Review of the facility's "Guidelines for Care Plan Development", dated June 2013, revealed care plans were developed to communicate care needs. Review of the procedures revealed the care plan was updated as needs changed.

Review of Resident #4's medical record revealed the resident was admitted by the facility on 05/22/14 with diagnoses which included Diabetes, Non-Alzheimer's Dementia, Depression, Atrial Fib, and Chronic Kidney Disease. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/29/14, revealed the facility had assessed the resident as being severely cognitively impaired. In addition, the MDS noted the facility had assessed Resident #5's functional status as needing extensive assistance of one person with transfers and the resident was non-ambulatory.

Further record review revealed Resident #4 sustained multiple falls and had care plan updates: on 06/01/14 while attempting to dress and the care plan was revised to use a tab alarm; on 07/18/14 the resident had two (2) falls to the floor from the bed very close together and the

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 280	<p>Continued From page 6</p> <p>care plan was revised to use a pressure alarm. However, the resident also had two (2) falls on 07/28/14 at 1:00 PM the resident was found on the floor trying to transfer self and at 9:30 PM the resident had rolled out of bed but no new interventions were put in place related to the falls.</p> <p>Interviews with the Registered Nurse (RN)/MDS Coordinator #3, on 08/14/14 at 6:50 PM and at 7:45 PM, revealed it was important to update care plans when falls occurred. She stated after a fall, the nurse completed the Fall Circumstance Assessment and intervention forms which identified the possible causes of the fall and new interventions. She further stated the forms were then reviewed by the Interdisciplinary Team (IDT) and the care plan was updated with the fall and intervention. However, the RN/MDS Coordinator #3 revealed Resident #5's care plan was not updated with interventions after the 07/28/14 falls because the staff nurse did not accurately complete the Fall Circumstance Assessments and Intervention forms and they were unable to come up with a root cause analysis to determine appropriate interventions. She further revealed the resident had multiple falls and the interventions listed on the form were already in place.</p> <p>Interview with the Corporate Consultant (CC), Director of Nursing (DON) and Administrator, on 08/15/14 at 9:40 AM. The CC stated when falls occurred it was important to identify the root cause and put appropriate interventions in place. After review of the Fall Circumstance Investigation from the 07/28/14 fall at 1:00 PM, the DON stated the nurse put an intervention to keep call bell in reach but did not complete the Environmental Inspection to identify this as the</p>	F 280		

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 280	Continued From page 7 cause. The CC stated the fall occurred when the resident was attempting to transfer and ensuring the resident's glasses were in place was not an appropriate intervention.	F 280			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the facility's policy, it was determined the facility failed to ensure the residents environment remained free of accidental hazards for two (2) of fifteen (15) sampled residents (Residents #1 and #7) and five (5) of seven (7) unsampled residents (Unsampled Residents A, B, F, G, & H). On initial tour Clorox Wipes, Lysol spray, a bottle of Crew Super Blue Mild Acid Bowl Cleaner (toilet bowl cleaner), and disposable razors were found in residents' rooms. Additionally, broken glass was observed to be left unattended for approximately fifteen (15) minutes in a resident's room.  The findings include:  Review of the facility's policy, titled "Environmental Policy and Procedures", dated 01/01/12, revealed it was the policy of the facility that safety was first and foremost when	F 323	<b>F 323 483.25(h) Free of Accident Hazards/Supervision/Devices</b>  <b>Criteria 1:</b> With Resident #1, broken glass was cleaned up immediately by KMA#6 when it was discovered on 8/12/14. Also, resident #F was asked for permission to remove her glasses from the bathroom by the CNCA#1 and the glasses were removed on 8/12/14. Residents A, B, #7, G, were asked for permission to remove the Clorox wipes, Lysol, razors and any other hazardous items from their rooms by the DHS and were removed or stored properly on 8/14/14.  <b>Criteria 2:</b> All residents rooms were observed on 8/14/14 by Enviromental staff/Environmental Supervisor/DHS to assure all hazardous items (including glass and chemicals) were removed and/or stored properly.  <b>Criteria 3:</b> Staff were reeducated by DHS/ADHS/Enviromental Director on the importance of proper storing of hazardous items. The inservice started on 9/9/14 and will be completed by 9/21/14. A letter will be mailed out to the families from the Executive Director on 9/9/14 reminding them of the importance of not bringing in hazardous items from home and/or keeping hazardous items properly stored.		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 323 Continued From page 8  
performing environmental service tasks on the campus. The policy revealed they should always consider the residents' and other team members' safety at all times. Continued review of the facility policy revealed every Environmental Service (ES) member would be provided Material Safety Data Sheet (MSDS) training for all chemicals he/she would be working with on the job. Additionally, every ES member was to report any known potential safety hazards on campus. Staff was to wipe up all spills on floors immediately and all flammable materials were to be stored in fire rated storage cabinets.

1. Observation on, 08/12/14 at 5:45 PM, revealed Resident #1 was not in his/her room. However, a broken wine/drinking glass was observed shattered on the floor beside Resident #1's recliner. Continued observation at 6:00 PM revealed the broken glass continued to remain on the resident's floor.

Observation, on 08/12/14 at 6:15 PM revealed Kentucky Medical Assistant (KMA) #6, picked the broken glass up off of Resident #1's floor.

Interview, on 08/12/14 at 6:17 PM, with KMA #6 revealed Resident #1 was drinking out of the glass and it must have fallen out of Resident #1's hand when he/she had fallen to sleep. KMA #6 reported Resident #1 had not realized he/she had broken the glass. Additionally, KMA #6 revealed she saw the broken glass before transporting the resident to the dining room, but reported she would have picked up the broken glass before the resident returned to his/her room. Continued interview revealed that a wandering resident could have gotten to the broken glass and possibly hurt/cut themselves. KMA #6 reported

F 323

**Criteria 4:**  
Ten percent of the resident rooms will be audited by the environmental staff weekly x four weeks, then monthly x 3 months to assure hazardous items are stored properly. The QA committee will review results of all audits weekly for four weeks then monthly for three months for compliance. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow up actions or education for staff as indicated.

**Criteria 5:**

9/22/14

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 323 Continued From page 9  
the shattered/broken drinking glass should not have been left in the resident's room and should have been removed once staff member noticed the glass was broken. Further interview revealed she tried to take the glass from the resident earlier, but he/she wanted something else to drink. She reported the glass should have been taken from the resident once he/she was finished drinking from the glass. KMA #6 further revealed the facility's drinking glasses should not be left in resident's rooms.

2. Observation, on 08/12/14 at approximately 6:25 PM, revealed two drinking glasses from dietary in Unsamed Resident F's bathroom. One (1) was in the shower, placed on the top ledge, the other was placed on the sink with some debris inside of it.

Interview, with Certified Nurse Care Assistant (CNCA) #2, on 08/12/14 at 6:30 PM, revealed she did not know why the resident's drinking glasses were stored in his/her bathroom. She reported she thought it might have been left to brush Unsamed Resident F's teeth and added she did not leave the drinking glasses in resident's bathroom. Continued interview with CNCA #2 revealed the drinking glasses should have been taken back to the kitchen once Unsamed Resident F was finished with them. She stated this was important so that the drinking glasses would not fall on the resident or get broken for a resident to step on. She reported the location of the drinking glasses could be a potential safety hazard for the resident and other wandering residents.

Interview, on 08/14/14 at 5:03 PM, with CNCA #1, revealed glass, when broken, should be cleaned

F 323

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 323	Continued From page 10 up immediately. Continued interview with the CNCA #1 revealed she had broken so many of the drinking glasses in the past. She stated that when this happened, she would remain with the glass, press the resident's call light and stay with the broken glass until it was cleaned up. She reported this was important for the safety of the residents. Further interview with staff revealed that the facility's drinking glass should not be left in resident's rooms when not in use. She reported that if she found a glass left in a resident's room, she would remove them because it was easy to bump into them and break them. She reported she had not seen drinking glasses left or stored in a resident's bathroom.  Interview with Registered Nurse (RN) #2, on 08/14/14 at 7:00 PM, revealed the broken glass should have been picked up immediately to prevent others from getting cut or hurt. Further interview with RN #2 revealed the drinking glasses should never be left in a residents room, unless they were still drinking out of it. RN #2 reported the drinking glasses should not have been left in Unsamped Resident F's bathroom due to the potential for it to fall and break and for infection control concerns.  Interview with the Administrator, on 08/14/14 at 8:20 AM and 08/15/14 at 9:40 AM, revealed that it would be her expectation that staff would pick up broken glass as soon as they become aware it was broken.  Interview with the Corporate Consultant, on 08/15/14 at 9:40 AM revealed the two (2) glasses observed in Unsamped Resident F's bathroom should not have been placed there. She reported it would be her expectation that staff would	F 323			

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 323 Continued From page 11  
remove the glass out of the resident's shower and monitor the glass for the safety of the resident.

3. Observation, on 08/12/14 at approximately 10:40 AM, during tour of the facility, revealed Unsampld Resident A had a bottle of Chlortox Wipes located in his/her bathroom and a can of Lysol located in his/her room. Continued observations of the tour revealed Unsampld Resident B had a bottle of Chlortox Wipes, which were sitting on top of his/her dresser in his/her room and a can of Lysol. Unsampld Resident B also had six (6) disposable razors in his/her bathroom, stored in his/her bath pan. Additionally, observation revealed one (1) disposable razor in Resident #7's bathroom, located on top of his/her plastic storage bin.

Interview, on 08/14/14 at 5:03 PM, with CNCA #1, revealed Lysol should not be left in a resident's room, however, she revealed she knew a lot of family members would bring the chemical in for the residents and leave it on the resident's shelf. CNCA #1 revealed that if the chemicals were ingested, they could be harmful and poisonous to the residents. She reported there were wanders on the unit who could get hold of the chemical. Continued interview with CNCA #1 revealed she had seen razors in the resident's bathrooms all the time, but did not report to nursing staff. She reported that if she needed to shave a resident, she would grab a bunch of razors at one time. Further interview with CNCA #1 revealed the razors should not have been left in the bathroom because it would be harmful to wandering residents.

Interview with CNCA #4, on 08/14/14 at 10:00 AM, revealed disposal razors should not be left in

F 323

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 323 Continued From page 12

residents rooms. She reported this was important because residents could attempt to shave themselves and had the potential for hurting themselves. She further revealed resident's could cut themselves on the face, fingers, or anywhere else. She reported there were residents who wandered into other resident's rooms. CNCA #4 added, if they (wanders) got a hold of the razors, it would be a safety hazard. CNCA #4 reported family would bring in Chlortox and Lysol and stated these chemicals should be put away because the chemicals could be hazardous if a resident got hold of it. Continued interview revealed she did not report these items in the resident's rooms.

Interview with Registered Nurse (RN) #2, on 08/14/14 at 7:00 PM, revealed Chlortox and Lysol should not be in resident's rooms. She reported the facility did not have a Material Safety Data Sheet (MSDS) for these products and they should be removed from the residents' rooms when observed, for the safety of the residents. Additionally, RN #2 reported the disposal razors should not have been in the the resident's room. She stated the disposal razors should be disposed of in a sharps containers when used and/or locked up. RN #2 reported the dangers of having the disposable razors out could result in a resident getting cut or, if used, a contracted blood born disease. RN #2 reported she was not aware of these items left in the residents' rooms.

Interview with the Environmental Services Supervisor, on 08/14/14 at 7:50 PM and 08/15/14 at 9:15 AM, revealed she did not have a Material Safety Data Sheet (MSDS) on Chlortox Wipes or Lysol. She stated housekeeping did not use those products to clean with. She further

F 323

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 323	<p>Continued From page 13</p> <p>revealed Lysol was an aerosol and should not have been in the facility and believed family must have brought those items into the facility. She stated that when facility staff saw these items, they should have confiscated these products. Additional interview with the Environmental Services Supervisor revealed she had removed these items from the residents' rooms in the past, but did not report it to anyone, she would "just dispose of them".</p> <p>Interview with the Corporate Consultant, on 08/15/14 at 9:40 AM revealed disposal razors should not be left in residents' rooms. The Corporate Consultant reported this was for the safety of wandering residents. She further revealed it would be her expectation that staff would dispose of razors in a sharps container and if residents were capable of using the razor, then the razor should have been locked in a bedside table.</p> <p>4. Observation, on 08/12/14 at approximately 11:40 AM, during facility tour revealed Unsamped Resident G had a plastic bottle of Crew Super Blue Mild Acid Bowl Cleaner in his/her bathroom.</p> <p>Interview, on 08/12/14 at 12:35 PM, with CNCA #9 revealed she thought the Crew Super Blue Mild Acid Bowl Cleaner was not supposed to be in the bathroom and was unsure why it was left there.</p> <p>Interview, on 08/12/14 at 12:41 PM, with Housekeeper #1 revealed she had removed the Crew Super Blue Mild Acid Bowl Cleaner from Unsamped Resident G's room because it was a hazardous chemical and was stored incorrectly in the resident's bathroom. She stated the product</p>	F 323		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 323 Continued From page 14  
was a hazardous chemical and was supposed to be locked in the housekeeping cart at all times.

Review of the Material Safety Data Sheet (MSDS), dated 05/16/07, for Crew Super Blue Mild Acid Bowl Cleaner revealed the product caused eye and skin irritation. Further review revealed it was moderately irritating to the skin and could result in severe eye irritation.

Interview with the Administrator, on 08/14/14 at 8:20 AM and 08/15/14 at 9:40 AM, revealed when chemical cleaners like Chlortox and Lysol were observed in residents' rooms, it should have been removed by staff. She reported all staff should be observing for the chemicals and should notify nursing/environmental staff when identified. Continued interview revealed this was important because wandering resident's could get hold of the chemicals and potentially harm themselves. Further interview with the Administrator revealed she was not aware of the chemicals found in the residents' rooms, but should have been made aware.

F 323

F 333 483.25(m)(2) RESIDENTS FREE OF SS=D SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to ensure one (1) of

F 333

**F333 483.25 (m)(2) Residents Free of Significant Med Errors**

**Criteria 1:**  
Resident #9 was monitored by the Medical Director and/or nursing staff for twenty-four hours after the time of the occurrence on 6/7/14 with no negative outcomes.

**Criteria 2:**  
No other new physician orders for the administration of insulin were obtained by RN#1 on 6/7/14.

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 333	<p>Continued From page 15</p> <p>fifteen (15) sampled residents (Resident #9) was free of significant medication error. Resident # 9 was given a Novolog (insulin medication) dose of forty (40) Units; however, the Physician revealed he had verbally ordered the resident be given Novolog four (4) Units.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Order: Medication Order Guidelines", undated, revealed orders taken verbally should be "read back" to the prescriber to decrease the chance of misunderstanding, misspelling, or other potential areas of error.</p> <p>During a Resident Interview on 08/13/14 at 9:05 AM with Resident #9, it was revealed that the resident received an incorrect dosage of insulin medication. The resident stated that he/she was to receive four (4) Units of insulin, but instead received forty (40) Units. The resident stated the Medical Director came to the facility and stayed with him/her to monitor the resident until he/she was well. Resident #9 further stated the process took several hours and the doctor stayed the entire time. The resident stated the nurse was the cause of the error.</p> <p>A phone interview with Registered Nurse (RN) #1 on 08/14/14 at 8:35 PM, revealed on 06/07/14 Resident #9's blood sugar was high and she attempted to contact the Advanced Registered Nurse Practitioner (ARNP) for Resident #9's Physician and was unsuccessful. She then attempted to contact Resident #9's Physician and was unsuccessful. She stated she called the facility's Medical Director and received a verbal order to administer forty (40) Units of insulin to</p>	F 333	<p><b>Criteria 3:</b> RN#1 was reeducated by the Corporate Consultant Nurse on 6/10/14 on the importance of repeating verbal orders back to the physician. Nurses were reeducated by the DHS/ADHS/Medical Records Nurse regarding physician orders with an emphasis on repeating of orders back to the physician for clarification. This re-education was started on 9/9/14 and will be completed by 9/21/14.</p> <p><b>Criteria 4:</b> Ten percent of nurses will be audited weekly x four weeks and then monthly x 3 months to assure they understand the importance of verbally repeating orders back to the physician. This audit will be conducted the DHS/ADHS/Medical Records Nurse. The QA committee will review results of all audits weekly for four weeks then monthly for three months to assure compliance. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow actions or education for staff as indicated.</p> <p><b>Criteria 5:</b></p>	9/22/14

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 333	<p>Continued From page 16</p> <p>the resident. She stated 40 Units did not appear to be a large dose to her. She stated she had given residents large doses before and did not see a problem with the order. She stated she administered the forty (40) Units of Novolog to Resident #9. Continued interview revealed Resident #9's Physician called her back and she reported what the Medical Director had ordered and the Physician informed her the dose was too high. He gave directives to monitor and assist in regulating the resident's blood sugar levels. She stated the Medical Director was notified of the incident of administering forty (40) Units of Novolog and he came to the facility to monitor and treat the resident. She stated when he arrived he questioned the forty (40) Units dosage given to the resident. He stated that he did not instruct her to give the resident such a high dose. He told her he ordered four (4) Units. She stated the Medical Director stayed with the resident until Resident #9's blood sugar levels were regulated. She stated that she received counseling for the error which included training related to repeating the information back to the Physician to ensure understanding of verbal.</p> <p>Review of the Physician Progress Notes documentation dated 06/07/14 at 10:40 PM revealed the Medical Director was contacted on 06/07/14 at 9:50 PM with regard to the resident's blood sugar levels at 418. He documented that he ordered four (4) Units of Novolog to be given to the resident to obtain a stable blood sugar level. Continued review of the Notes revealed forty (40) Units were given in error.</p> <p>Interview with the Medical Director, on 06/13/14 at 8:00 PM revealed he received a call on 06/07/14 with regard to Resident #9's blood sugar</p>	F 333		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 333 Continued From page 17  
level of 418. He stated the nurse informed him that she was unable to reach Resident #9's Primary Care Physician (PCP). He stated he gave an order to give the resident four (4) Units of Novoiog. He stated it was not until he received a phone call from the resident's PCP when he realized the nurse failed to give the resident the correct dosage of insulin. He stated the PCP informed him that the nurse gave Resident #9 forty (40) Units of Novolog. He stated he confirmed with the PCP that his orders were for four (4) Units not forty (40) Units. The Medical Director stated he then entered the facility at about 10:40 PM and stayed with the resident until he was stable. He stated the resident's spouse and daughter were notified and they came to the facility. He stated he never signed an order for forty (40) Units because he ordered four (4) Units.

F 333

Interview with the Corporate Consultant and Administrator, on 08/14/14 at 10:45 AM, revealed RN #1 called the Corporate Consultant on 06/07/14 at 10:30 PM and stated the Medical Director ordered forty (40) Units of insulin for Resident #9. Afterwards Resident #9's Physician returned a phone call to RN #1 and RN #1 informed him of the Medical Director's orders of (forty) 40 Units of Novolog. The Corporate Consultant stated the investigation revealed the Medical Director said that he ordered four (4)Units of insulin. The Corporate Consultant stated RN #1 admitted that she did not repeat the order back to the Medical Director, which was the facility's policy to help prevent errors with verbal medication orders. The Corporate Consultant stated the facility determined it was a medication error on the part of RN #1.

F 356 483.30(e) POSTED NURSE STAFFING

F 356

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 356  
SS=C

Continued From page 18  
INFORMATION

The facility must post the following information on a daily basis:

- o Facility name.
- o The current date.
- o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
  - Registered nurses.
  - Licensed practical nurses or licensed vocational nurses (as defined under State law).
  - Certified nurse aides.
- o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:

- o Clear and readable format.
- o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and review of the Daily Nurse Staffing form, it was determined the facility failed to post the Daily Nurse Staffing

F 356

**F 356 483.30(e) Posted Nurse Staffing Information**

**Criteria 1:**  
Daily Nurse Staffing data was posted at the beginning of each shift on the skilled living units of the facility in a clear and readable format by the Staffing Coordinator/DHS/ADHS on 8/15/14.

**Criteria 2:**  
Daily Nurse Staffing data was posted at the beginning of each shift on the skilled living units of the facility in a clear and readable format by the Staffing Coordinator/DHS/ADHS on 8/15/14.

**Criteria 3:**  
The Staffing Coordinator was educated by the DHS on 8/15/14 on the importance of assuring daily nurse staffing data is posted at the beginning of each shift in a readable format.

**Criteria 4:**  
The Daily Nurse Staffing data will be audited by the DHS/ADHS weekly x four weeks and then monthly x 3 months to assure compliance. The QA committee will review results of all audits weekly for four weeks then monthly for three months to assure compliance. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow actions or education for staff as indicated.

**Criteria 5:**

9/22/14

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 356	Continued From page 19 data at the beginning of each shift on the skilled living units of the facility. In addition, staffing information was not displayed in a clear and readable format.  The findings include:  Interview with the Administrator on 08/14/14 at 5:00 PM, revealed the facility did not have a policy related to the posting of the nurse staffing hours; however, she stated the facility followed the regulation for the posting of staffing information.  Observation of the posted Daily Nurse Staffing form on the skilled unit on 08/12/14 at 5:20 PM, revealed the posting covered all three (3) shifts for the twenty-four (24) hour period and was not clear and readable. Subsequent observation, on 08/13/14 at 10:00 AM, and 08/14/14 at 9:00 AM revealed staffing information for the skilled unit was posted, again for all three (3) shifts and was not clear and readable.  Interview with the Administrator, on 08/15/14 at 9:40 AM, revealed the staffing list should be posted on the wall in a clear plastic frame, in a location which could readily be seen by visitors. She stated the facility posted the nurse staffing hours daily in the morning, and she was not aware of the requirement for staffing to be posted at the beginning of each shift.	F 356			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371			

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 371 Continued From page 20  
authorities; and  
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and review of facility's policy, it was determined the facility failed to store, distribute and serve food under sanitary conditions as evidenced by observation of staff members using improper techniques for hand washing and changing of gloves after direct contact with other surfaces while serving residents' food, and entering the dietary area with no hair covering, and observation during initial tour at building one (1) and building two (2) revealed dented cans of food product available for resident consumption, undated food products stored on shelves and scoops stored upright in drawers.

The findings include:

1. Review of the facility's policy titled, "Hand Washing", undated, revealed staff was to wash their hands when entering the Nutrition Services area, before and after handling food, and whenever hands became soiled.

Observation of the noon meal on 08/13/14, revealed Dietary Aide #8 serving resident food on the tray line. Dietary Aide #8 was observed to open a package of hamburger buns, remove a bun, place it on a plate, use tongs to get a hamburger patty from the serving line, place it on

F 371: F371 483.35 (i) Food Procure, Store/ Prepare/Serve-Sanitary

**Criteria 1:**  
The identified dented cans were removed immediately from the prep area by the Director of Food Services and disposed of in the garbage can. The dietary employee #8 was redirected immediately by the Director of Food Service to change her gloves and wash her hands after touching the bun wrapper. The dietary employee regloved prior to continuing the meal service. The CNCA that entered the kitchen without a hair covering was redirected immediately by the Executive Director to cover her hair after entering the kitchen. The identified food items with no date were immediately dated by the Cook in building #2 and the scoops in the drawer were stored properly in the drawer by the Cook in building #2.

**Criteria 2:**  
The identified dented cans were removed immediately from the prep area by the Director of Food Services and disposed of in the garbage can. The dietary employee #8 was redirected immediately by the Director of Food Service to change her gloves and wash her hands after touching the bun wrapper. The dietary employee regloved prior to continuing the meal service. The CNCA that entered the kitchen without a hair covering was redirected immediately by the Executive Director to cover her hair after entering the kitchen. The identified food items with no date were immediately dated by the Cook in building #2 and the scoops in the

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 371	<p>Continued From page 21</p> <p>the bun, set the plate on the bar as she waited for lettuce, tomato and mayonnaise to be put on the burger. Continued observation revealed Dietary Aide #8 then sat the plate on top of the tray line to be completed, removed the glove from her right hand, put it in the trash, returned to the tray line area and put a new glove on her right hand, all without washing her hands. Dietary Aide #8 was observed to then be returning to the line to proceed when the Surveyor intervened and stopped her.</p> <p>Interview with Dietary Aide #8 on 08/13/14 at 11:55 AM, revealed she should have washed her hands when she changed gloves, but stated she had been nervous. Dietary Aide #8 stated she knew "when to wash" her hands and change her gloves. She confirmed it was cross contamination when she opened the hamburger buns, took one (1) out and continued on the tray line without washing her hands and changing gloves.</p> <p>Additional observation, on 08/13/14 at 12:00 PM, revealed a Certified Nurse Care Assistant (CNCA) #5 entered the kitchen and proceeded to obtain silverware from a tray at the end of the tray line, with no hair covering in place. Interview with CNCA #5 on 08/13/14 at 12:00 PM, revealed she was aware she was to put a hair net on anytime she entered the kitchen; however, stated she "just forgot".</p> <p>Interview with Dietary Manager #10 on 08/14/14 at 7:15 PM, revealed Dietary Aide #8 had received training on hand washing and cross contamination. She stated Dietary Aide #8 should have removed the buns from the bag before tray line started, and removed her gloves and washed</p>	F 371	<p>drawer were stored properly in the drawer by the Cook in building #2. The Director of Food Service audited the storage room and canned storage rack on 8/12/14, removed any dented cans, and disposed of the cans in the garbage. The Director of Food Service also audited the drawers on 8/12/14 to ensure all scoops were properly stored.</p> <p><b>Criteria 3:</b> The Director of Food Service/Assistant Director of Food Service educated all dietary employees starting on 9/9/14 and will be completed by 9/21/14 regarding the regulation of food service sanitary conditions which included disposing of all dented cans properly, storing scoops properly, and wearing hair coverings. The Director of Food Service/Assistant Director of Food Service educated all dietary employees starting on 9/9/14 and will be completed by 9/21/14 regarding proper glove use and hand washing procedures.</p> <p><b>Criteria 4:</b> The Director of Food Service/Assistant Director of Food Service will audit all storage areas for dented cans, scoop storage, and hair covering usage weekly x four weeks and then monthly x three months to assure compliance. The Director of Food Service/Assistant Director of Food Service will audit for proper glove usage and handwashing procedures weekly x four weekly and monthly x three months to</p>		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 371 Continued From page 22  
her hands anytime she touched anything which was considered as not being clean in her work area. The Dietary Manager stated Dietary Aide #8 should remove her gloves or wash her hands if they became soiled. Additionally, the Dietary Manager stated staff had received training on ensuring they wore a hair covering when in the kitchen. She stated the CNCA should have covered her hair before she proceeded to the tray line to obtain anything, and her dietary staff should have stopped the CNCA.

2. Observation of the kitchen, at building one (1) of the facility, on initial tour on 08/12/14 at 10:25 AM, revealed four (4) cans of rice pudding and two (2) cans of cream of potato soup observed as dented and stored on a shelf available for resident consumption. Observation during initial tour, at building two (2) of the facility, revealed a box of instant mashed potato pearls and a box of scalloped potatoes with no opened date, stored on a shelf, and two (2) scoops stored upright in a drawer.

Continued interview with Dietary Manager #10, on 08/14/14 at 7:15 PM, revealed the dented cans should not have been on the shelf for use, but should have been placed in an area in the back of the kitchen which was designated for dented cans. She stated food in dented cans could be compromised causing bacteria to grow and residents could get "very sick" after consumption. She commented the boxes of potatoes at building two (2) should have been dated when opened, and she would make sure they were discarded. The Dietary Manager also stated the scoops should have been stored up side down to prevent any water droplets being left in them and to prevent possible contamination of food items.

F 371 **assure compliance. The QA committee will review results of all audits weekly for three months then monthly for 3 months. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow up actions or education for staff as indicated.**

**Criteria 5:**

9/22/14

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 371	Continued From page 23  Interview with the Administrator, on 08/15/14 at 10:30 AM, revealed her expectations was for all staff to follow policy and procedure for all areas, including ensuring they wore a hair covering when entering the kitchen and ensuring good hand washing techniques were utilized in the kitchen.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	<b>F431 483.60(b),(d) (e) Drug Records, Label/Store Drugs &amp; Biologicals</b>  <b>Criteria 1:</b> For Residents #5, #9, #10, #11, 12, 13, B, C, D, medications were removed from their rooms (with permission) by the DHS/Staffing Coordinator/ED and all non medication items were removed from the medication refrigerators by the DHS /Medical Records Nurse/Staffing Coordinator 8/14/14.  <b>Criteria 2:</b> Residents rooms and medication refrigerators were audited by the DHS/Medical Records Nurse/ Staffing Coordinator on 8/18/14 to assure all medications and non medication items were stored properly.  <b>Criteria 3:</b> Nursing staff were reeducated by the DHS/ADHS/Medical Records Nurse on the importance of storing medication under lock and non medication items not stored in medicaiton refrigerator. This inservice was started on 9/9/14 and will be completed by 9/21/14.		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 431 Continued From page 24  
abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and review of the facility's guidelines and policy, it was determined the facility failed to ensure appropriate storage of drugs in accordance with State and Federal laws for six (6) of fifteen (15) sampled residents (Residents #5, #9, #10, #11, #12, and #13) and three (3) of seven (7) unsampled residents (Unsampled Residents B, C, and D) as evidenced by observations which revealed medications stored in an unsecured manner in the resident rooms and accessible to other residents. In addition, observation of the four (4) of five (5) medication rooms revealed food items stored in the medication refrigerators.

The findings include:

1. Review of the facility's "Guidelines for Self Administration of Medications" revealed residents were assessed for safety by a licensed nurse to ensure safe resident administration of medication. The policy also noted medication was to be kept in a locked drawer in the residents' room.

Observation on initial tour of Resident #5's room, on 08/12/14 at 11:03 AM, revealed Resident #5 had Calazime Protectant Paste and Perineal and Skin Cleanser stored on his/her dresser. Review of Resident #5's Physician's orders, dated

F 431

**Criteria 4:**  
Ten percent of the resident rooms and medication refrigerators will be audited by the DHS/ADHS/Medical Records Nurse/ Staffing Coordinator weekly x four weeks and then monthly x 3 months. The QA committee will review results of all audits weekly for four weeks then monthly for 3 months to assure compliance. The Committee will monitor the effectiveness and compliance with the plan and update and develop plans of action to be carried out. The results of the audits will be tracked and trended with follow actions or education for staff as indicated.

**Criteria 5:**

9/22/14

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 431	<p>Continued From page 25</p> <p>08/01/14 thru 08/31/14, revealed the resident was ordered Calazime Protectant Paste to be applied topically to the Bilateral inner Gluteais every shift and upon every brief changes. However, the Physician's order did not state that resident may keep this prescription at bedside. Further review of the Physician's orders revealed the resident was ordered Barrier Cream to perineal and/or perianal area as needed. The Physician's orders state that Resident #5 may keep this prescription at bedside. Additionally, review of the resident's Nursing Admission Assessment and Data Collection Report, dated 03/24/13, revealed the resident was not assessed on safely self administration of medication.</p> <p>Observation of Resident #9's room, on 08/12/14 at 10:53 AM and 5:44 PM revealed Clarus Antifungal Cream Tolnaftate 1% and Kera-42 Cream Urea 42% was stored on the resident's counter top. Additional observation reveled Remedy Skin Repair Cream was in the resident's bathroom. Review of the resident's record revealed no documented evidence of a Physician's orders for bedside storage or self administration of the medication. Additionally, review of resident's Nursing Admission Assessment and Data Collection Report dated 05/23/14 revealed the resident was assessed and determined unable to store and/or safely self administer medication.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 08/12/14 at 10:53 PM revealed medications should be stored either in a bedside drawer or locked container/medication cart. She stated the medication and creams in Resident #9's room should not be out. She stated wandering residents could get into the medication.</p>	F 431			

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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)	
F 431	<p>Continued From page 26</p> <p>On 08/12/14 at 11:20 AM during the initial tour, observation revealed a bottle of eye drops was sitting on the Resident #10's bedside table. Observation of Resident #10 room, on 08/14/14 at 10:50 AM revealed the eye drops were still sitting in the residents room. There were six (6) bottles of Systane Ultra eye drops sitting on the resident's bed side table, three (3) of the bottles were unopened and two (2) of the unopened bottles had an expiration date of 07/14. One (1) bottles had an expiration date of 11/12. Two (2) of the three (3) opened bottles had expiration dates of 04/14 and one (1) bottle had an expiration date of 04/12. Review of the resident record revealed no documented evidence of a Physician's order for eye drops, no assessment of the residents ability or safety to self administer the eye drops.</p> <p>Interview with Resident #10, on 08/14/14 at 4:15 PM, revealed that he/she had used the eye drops for many years.</p> <p>Interview with LPN #3, on 08/14/14 at 4:30 PM revealed she was not sure where the eye drops had come from or how long they had been there. She further stated she would notify the Physician to ask about an order and would also notify the family to not bring any medication, even over the counter, into the resident and would explain why. She confirmed that the resident had not been assessed to self medicate.</p> <p>Observation on initial tour of Resident #11's room, on 08/12/14 at 11:45 AM, revealed Resident #11 had a prescribed bottle of Selsun Blue located on a shelf in his/her shower. Additionally, on 08/14/14 at 7:00 PM, tour with Registered Nurse (RN) #2, revealed a bottle of Miconazorb Powder</p>	F 431		

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 431	<p>Continued From page 27</p> <p>AntiZeasorb Powder laying in a plastic bag on top of the resident's dresser. Review of Resident #11's Physician's Order, dated 08/01/14 through 08/31/14, revealed the resident was ordered Selsun Blue Medicated Shampoo to be used for itchy, flaky scalp two (2) times a week with showers. Continued review of the Physician order revealed the resident was prescribed Micoazorb AF two percent (2%) Powder Antizeasorb Powder seventy-one (71) grams to be applied to the buttocks every shift and as needed. However, record review revealed no documented evidence of an order for the prescription to be kept at bedside.</p> <p>Interview with Resident #11, on 08/14/14 at 3:00 PM, revealed staff assisted him/her with scheduled showers. Resident #11 stated staff used the Selsun Blue to wash his/her hair because he/she could not complete the task on his/her own.</p> <p>Interview with Certified Nurse Care Assistant (CNCA) #3, on 08/14/14 at approximately 4:30 PM, revealed medications should not be stored in resident's room. She reported that if she located the prescribed medications in the resident's rooms, she would contact the nurse to find out if they knew the medication was there. She stated if the nurse was not aware, then she would give the medication to the nurse. In regards to Resident #11, CNCA #3 reported Resident #11 received his/her showers during the day, thus she was not responsible for leaving the Selsun Blue Shampoo in the shower room. She reported she was, however, aware that the shampoo was stored on the ledge in the resident's shower room. She reported she was not for certain were else it should have been stored, but revealed it</p>	F 431			

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 431 Continued From page 28  
should have been given to the nurse or stored in the resident's locked bedside table.

Interview with CNCA #1, on 08/14/14 at 5:03 PM, revealed medications should not be stored in residents' rooms. She reported she was not certain if residents had locked boxes. CNCA #1 reported Resident #11 needed assistants with his/her shower and staff should have stored his/her medications in the treatment cart. She reported Resident #11's powder should be stored in his/her locked bedside table. CNCA #1 reported it should not have been on top of his/her dresser.

Interview with CNCA #4, on 08/14/14 at approximately 10:00 AM, revealed medications should not be allowed in resident's rooms. She reported that any thing that had a prescription should be left in the medication cart. She reported this was important because a resident could have an allergic reaction to the medication and it could be fatal for the resident.

Interview with RN #2, on 08/14/14 at 7:00 PM, revealed prescribed medications should have been stored in the treatment cart, not in residents' rooms. She reported that to her knowledge, the residents were not able to self-administer based upon their assessments that would have been completed during admission. RN #2 stated the prescribed medications should not have been left in resident's rooms. Continued interview with RN #2 revealed Resident #11 required assistants with showers and his/her Selsun Blue should have been locked up along with his/her medicated powder in the treatment cart.

Observation of Resident #12's room, on 08/12/14

F 431

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
(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 431	<p>Continued From page 29</p> <p>at 11:29 AM, with RN/MDS Coordinator #3 revealed Prescription Ofloxacin Eye drops 0.3% and Septine eye drops in he resident's bathroom area. Further observation, on 08/14/14 at 3:33 PM, of Resident #12's room revealed the resident had Zymaxid Ophthalmic Solution 0/5% (eye drops) and Systane Eye Drops on a chest by his/her bed.</p> <p>Review of the Resident #12's Physician's orders revealed no order for bedside storage or self administration of medication. Review of the Nursing Admission Assessment, dated 05/09/14, revealed the facility assessed the resident as unable to safely administer medications, including eye drops.</p> <p>Interview, on 08/12/14 at 11:29 AM, with RN/MDS Coordinator #3 revealed the medications should not have been in Resident #12's room. She stated the nurses did rounds and must not have seen the medications.</p> <p>Interview, on 08/14/14 at 5:41 PM, with LPN #4 revealed Resident #12 was not able to self medicate per assessment and the medications should not have been stored in Resident #12's room. The LPN stated the resident had a family member, an Optometrist, who brought in eye drop medications. The LPN revealed if staff saw medications in a resident's room they were to remove them and store them properly.</p> <p>Observation of Resident #13's room, on 08/14/14 at 3:42 PM, revealed Equate Nasal Spray, Equate Miconazole Vaginal Antifungal Cream, Muscle Care and Naphcan A Eyedrops on the shelf of the resident's bedside table. Review of the resident's record revealed no Physician's Orders for</p>	F 431		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 431 Continued From page 30  
bedside storage or self administration of the medication. Additionally, review of the resident's Nursing Admission Assessment and Data Collection Report dated 08/08/14 revealed the resident was assessed and determined unable to store and/or safely self administer medication.

Observation on initial tour of Unsampled Resident B's room, on 08/12/14 at 11:23 AM, revealed a tube of Remedy Calazime Skin Paste topical Body Shield Cream seated on top of his/her dresser. Review of resident's Physician's orders, dated 08/01/14 through 08/31/14, revealed an order that the resident may use a Barrier Cream to perineal and/or perianal area as needed and may keep at bedside. However, review of resident's Nursing Admission Assessment and Data Collection Report dated 05/22/14, revealed the resident was assessed and determined unable to store and/or safely self administer medication.

Observation on initial tour of Unsampled Resident C's room, on 08/12/14 at 11:35 AM, revealed a bottle of Remedy Dimethicone Skin Protectant displayed on his/her dresser and a prescribed bottle of Ketoconazole shampoo on a shelf within the resident's shower. Review of Unsampled Resident C's Physician's order revealed the resident was prescribed Ketoconazole two percent (2%) shampoo into entire scalp, to be left on for three (3) minutes, then rinsed out weekly. Continued review revealed a Physician's order for a moisture barrier to be placed topically to the resident's coccyx/perineal area as needed. Continued review of the orders revealed there was no order for these treatments/prescriptions to be left at bedside. Additionally, review of the resident's Nursing Admission Assessment and

F 431

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 431 Continued From page 31  
Data Collection Report, dated 01/12/13, revealed the resident was assessed and determined unable to store and/or safely self administer medication.

Observation on initial tour of Unsampied Resident D's room, on 08/12/14 at 11:37 AM, revealed two (2) bottles of Remedy Antimicrobial Cleanser and Remedy Calazime Skin Paste body shield located on his/her plastic container in his/her bathroom. Review of Unsampied Resident D's Physician's order, dated 08/01/14 through 08/31/14, revealed an order that the resident may use barrier cream to perineal and/or perianal area as needed and may be kept at bed side. Continued review of the Physician's order revealed a moisture barrier should be applied topically to coccyx/perineal area as needed. The order did not state if this could be kept at bedside. Additionally, review of resident's Nursing Admission Assessment and Data Collection Report, dated 01/03/13, revealed the resident was assessed and determined unable to store and/or safely self administer medication.

Interview with the Director of Health Services, on 08/14/14 at 10:51 PM revealed her expectations were to have bedside medications stored in a locked compartment or bedside drawer if the resident had been assessed to do so. She stated staff was suppose to monitor for unsafe items in the resident's room.

Interview with the Administrator, on 08/14/14 at 10:54 AM revealed her expectations were to have bedside medications stored in bedside drawer. She further stated prescribed medication that did not indicate bedside storage or self medication should be stored on the medication and/or

F 431

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 431	<p>Continued From page 32 treatment cart.</p> <p>Interview with the Nursing Consultant, on 08/15/14 at 9:40 AM, revealed the process for residents to have medications in their rooms would be to have the residents complete a self determination form to prove they were capable of doing so. The Nursing Consultant revealed the Unit Nurse would complete the Self-Determination form on behalf of the resident. The Nursing Consultant revealed that the Physician's Orders would then state the resident could keep their medications at bedside; however, it would be the facility's policy to place the medications in a locked bedside drawer. The Nursing Consultant revealed it was the responsibility of everyone to monitor for medications that were sitting out on residents' dressers. She reported that staff should ask residents if they could remove the medications and explain that it was for the safety of other residents. Continued interview with the Nursing Consultant revealed it was her expectation that staff would observe any medications that were out and inform the nurses so that they could talk to the resident about putting the medications away. She revealed this was important for the safety of the residents.</p> <p>2. Review of the facility's policy: "Medication Storage In the Facility", effective date 02/01/10, revealed medications stored in the refrigerator were to be kept in closed and labeled containers and separated from fruit juices, applesauce, and other foods used in administering medications. The policy further stated other foods, such as employee lunches and activity department refreshments, were not to be stored in this refrigerator.</p>	F 431		
-------	--	-------	--	--

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

PRINTED: 08/29/2014  
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  08/15/2014
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509	
(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 431	Continued From page 33  Observation of the medication storage room on the Neighborhood, on 08/14/14 at 12:00 PM, with the Neighborhood Director revealed medications were stored together with food items in the medication refrigerator. Interview with the Neighborhood Director revealed medications and food items were not to be stored together but knew both were being stored in the medication refrigerator. Further interview with the Director revealed they tried to get a small refrigerator for the medications, but it was not in place.  Observation of the 300 Hall medication room, on 08/14/14 at 3:15 PM, with LPN #4 revealed the medication refrigerator had milk, pudding snacks and orange juice stored in the refrigerator along with medications stored in the drawers. Interview with LPN #4 revealed the orange juice was for diabetic residents, if needed, and the other food items were for medication pass. The LPN also revealed none of the food items were stored as snacks for the residents.  Observation of the 200 Hall medication room, on 08/14/14 at 4:20 PM, with RN #2 revealed there were two (2) bottles of beer for a resident, two (2) bottles of Ketchup, two (2) containers of applesauce, four (4) pudding snacks, and soda cans (coke, diet coke, sprite) and nine (9) small cartons of milk stored in the medication refrigerator. Further observation revealed the medications in the refrigerator were stored in containers or drawers and were separated from the food items. Interview with RN #2 revealed the ketchup, milk, and beer should not have been stored in the medication refrigerator. The RN further revealed she had not seen residents take milk with medication pass and the beer was for a	F 431		

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IC PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431	<p>Continued From page 34 resident who had a Physician's order.</p> <p>Observation of the 100 Hall medication room, on 08/14/14 at 4:26 PM, with LPN #5 revealed the medication storage refrigerator had small milk cartons, soda cans, and yogurts. Further observation revealed medications were separated from the food items by being stored in containers or drawers. The LPN stated she worked evening shift and they did not have access to cold cokes and yogurts at night so they kept them in the refrigerator for the residents. The LPN further stated the milk was for a diabetic resident.</p> <p>Interview with the facility's Pharmacist Consultant, on 08/14/14 at 6:27 PM, revealed the medication room refrigerators were for medication storage only. The Pharmacist stated he was new to the facility and had only visited one (1) time, but always told facilities nothing, other then medication, was to be stored in the refrigerator.</p> <p>Interview, on 08/14/14 at 6:42 PM, with the Corporate Consultant (CC) revealed the facility's medication storage policy was from the pharmacy and according to the policy non-medication items were allowed to be stored in the medication refrigerators as long as there were separate from the medications. The CC revealed medications were to be stored in a drawer or separate containers. She further revealed the Pharmacist had never reported they were not allowed to store food in the the refrigerator.</p> <p>Interview, on 08/14/14 at 8:20 PM, with the Director of Nursing (DON) revealed food items, used during medication pass and snacks, were also stored with medications in the medication refrigerators. The DON further revealed she</p>	F 431		
-------	---	-------	--	--

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

PRINTED: 08/29/2014  
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  08/15/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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 431	Continued From page 35 expected only medications to be stored in the medication refrigerator.	F 431		

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

PRINTED: 08/26/2014  
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 02 - THE LEGACY AT THE WILLOWS  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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
--------------------	--	---------------	---	----------------------

K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70 (a)

BUILDING: 02

PLAN APPROVAL: 02/02/11

SURVEY UNDER: 2000 New

FACILITY TYPE: NF

TYPE OF STRUCTURE: One (1) story, Type V (111) Protected

SMOKE COMPARTMENTS: Four (4) smoke compartments.

COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM

SPRINKLED SYSTEM, Complete automatic (one (1) wet and one (1) Dry) System. The dry sprinkler system covers canopies and the attic. The wet sprinkler covers interior areas.

EMERGENCY POWER: Type II Generator. Fuel source in natural gas

A Life Safety Code Survey using a 2786S (Short Form) was initiated and concluded on 08/13/14. The facility (The Legacy) was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).

K 000



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE 9/8/14

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.

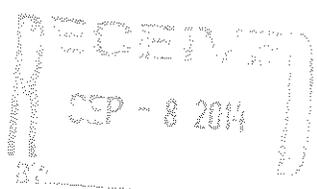
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2014  
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 01 - THE WILLOWS AT HAMBURG  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509
--	---

(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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 6/13/11</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111) Protected</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (Original Installation 10/04/12)</p> <p>FULLY SPRINKLED, SUPERVISED Two (2) wet and Three (3) Dry Systems Original Installation 09/21/12.</p> <p>EMERGENCY POWER: Type II Diesel Generator. (Original Installation 10/03/12)</p> <p>A Life Safety Code Survey using a 2786S (Short Form) was initiated and concluded on 08/13/14. The facility was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).</p>	K 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* EXECUTIVE DIRECTOR TITLE: \_\_\_\_\_ (X6) DATE: 9/8/14

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.