

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

PRINTED: 11/05/2014
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 C 10/22/2014
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 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00022320 and KY00022356 was initiated and concluded on 10/22/14. KY00022320 was unsubstantiated with no deficiencies cited. KY00022356 was substantiated with related deficiencies cited at a highest Scope and Severity of a "D".	F 000		10/14/2014
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Resident #5 was Discharged from the facility on 10-1-2014. 2. Residents with a change of condition clinical record has been audited by the DHS/ADHS/Medical Records on 11-13-2014 to assure all change in condition or change that significantly impacted the resident has been reported to the POA. 3. Licensed nurses, including RN#2 has been in-serviced by the DHS/ADHS/ Medical Records on the policy and procedure for family notification. 4. Ten percent of the clinical records will be audited by the DHS/ADHS/Medical Records to assure the POA has been notified of significant treatment change or change in condition for 3 consecutive months, then quarterly x 3 months. All	

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

Elizabeth Plaur

TITLE

E.D.

(X6) DATE

11-14-2014

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: 11/05/2014
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 C 10/22/2014
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 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to notify the responsible party for a change in condition altering treatment for one (1) of five (5) sampled residents (Resident #5). The facility failed to notify or inform Resident #5's Power of Attorney (POA) of a new medication ordered to alter his/her treatment due to a change of status in the resident.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Change in Condition Form Guidelines", updated January 2008, revealed the purpose was to facilitate thorough and consistent review and completion of the nursing process through the use of a form which documented the change in a resident's status, Physician response, care plan update and notification of change. Continued review of the Policy revealed the nurse should document notification of the Physician, responsible party and any other pertinent person or staff of a resident's current status.</p> <p>Record review revealed the facility admitted Resident #5 on 08/29/14, with diagnoses which included Atrial Fibrillation, Heart Failure, Urinary Tract Infection, Cerebrovascular Accident, and Non-Alzheimer's Dementia with Unspecific Behavioral Disturbances. Review of the Admission Minimum Data Set (MDS)</p>	F 157	<p>audits will be presented to the QA committee for review and need for further audits.</p> <p>5. Date: 11-27-2014</p>	

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

PRINTED: 11/06/2014
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 C 10/22/2014
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 157	<p>Continued From page 2</p> <p>Assessment dated 09/05/14, revealed the facility assessed Resident #5 to have a Brief Interview for Mental Status (BIMS) score of seven (7) indicating severe cognitive impairment.</p> <p>Continued record review revealed a "late entry" Nurse's Note, dated 09/18/14, written by Registered Nurse (RN) #2, which stated on 09/03/14 at approximately 10:30 PM, Resident #5 was in his/her room "screaming" "help me", and the nurse entered the room to ask if she could help the resident. The Note revealed Resident #5 stated "people" were trying to "hurt" him/her, the nurse reassured the resident, placed the call light button in his/her hand and told him/her she would be "right outside" the room door. According to the Note, Resident #5 started "screaming" again after she left the room, saying "bring me a gun" and the nurse returned to his/her room. Per the Note, Resident #5 stated to the nurse, he/she "had a gun and would use it". Continued review revealed the nurse attempted to reassure Resident #5 again; however, the resident was "visibly upset" with fear of being hurt by others, and tears "falling down" his/her face. Further review of the Note revealed the nurse notified the Advanced Practice Registered Nurse (APRN) who ordered a one (1) time dose of Haldol (an anti-psychotic medication not approved to treat mental problems caused by Dementia in the elderly) three (3) milligram (mg) intramuscularly (IM).</p> <p>Review of the Physician/Prescriber's Telephone Order, dated 09/03/14 at 10:45 PM, written by Registered Nurse (RN) #2, revealed an order for Haldol 3 mg IM times one (1) dose. Review of the September 2014 Medication Administration Record (MAR) revealed the Physician's order for</p>	F 157		

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

PRINTED: 11/05/2014
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 C 10/22/2014
--	--	--	---

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 157	<p>Continued From page 3</p> <p>the Haldol three (3) mg IM. Continued review of the MAR revealed the Haldol was initiated as administered on 09/03/14 at 10:45 PM by RN #2.</p> <p>However, further record review revealed no documented evidence Resident #5's responsible party/POA was notified of the resident's fearful behaviors, of the Physician being notified or of the order for the Haldol which was received and administered.</p> <p>Interview with Resident #5's POA on 10/22/14 at 4:55 PM, revealed she, nor any other family members were notified when the resident received the new medication of Haldol on 09/03/14. The POA stated the family would not have wanted Resident #5 to have the medication due to the possibility of it having negative side effects on the resident. The POA stated a former facility staff employee informed the family of Resident #5 receiving the Haldol IM injection a "few days later".</p> <p>Interview with RN #2 on 10/22/14 at 6:00 PM, revealed she did not think she had notified Resident #5's family. RN #2 indicated she was so concerned about Resident #5 "being scared" and upset and not being able to get the resident to calm down she had failed to do this. RN #2 stated she did write a Nurse's Note that day and had filled out a Change of Condition Form; however, record review revealed no documented evidence of this documentation.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 10/22/14 at 3:20 PM, revealed nurses should contact residents' family with any new Physician orders. She stated she would "personally" contact family prior to giving any new medications</p>	F 157		
-------	--	-------	--	--

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

PRINTED: 11/05/2014
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 C 10/22/2014
--	--	--	---

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 157	<p>Continued From page 4</p> <p>or treatments, and would document all notifications in the resident's medical record.</p> <p>Interview with RN #1 on 10/22/14 at 3:35 PM, revealed she would contact a resident's family any time there was a change of condition in the resident, such as, with a new medication or new treatment. RN #1 stated she would document the notification of the family in the medical record.</p> <p>Interview with LPN #2 on 10/22/14 at 3:40 PM, revealed she would contact the resident's family prior to administering a new medication for their approval and would document the family notification in the medical record.</p> <p>Interview with the Director of Health Services (DHS) on 10/22/14 at 7:00 PM, revealed it was her expectation for facility staff to notify residents' responsible family members and to document the notification in the resident's medical record. The DHS indicated RN #2 should have done this for Resident #5; however, the DHS was unable to provide documented evidence of the resident's POA being notified of a change in condition on 09/03/14, as per the facility's policy.</p>	F 157		
-------	---	-------	--	--