

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

PRINTED: 12/11/2013  
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 11/26/2013
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40508	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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	F 000		
F 280 SS=D	<p>An Abbreviated Survey Investigating KY#00021015 was initiated 11/25/13 and concluded on 11/26/13. KY#00021015 was substantiated with deficiencies cited. The highest Scope and Severity was a "D".</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for two (2) of nine (9) sampled residents (Resident #4 and #6).</p>	F 280	<p>1. Resident #4 and #6 care plans were updated by the IDT (DHS/ADHS, medical records nurse) to assure accurate plan of care. At the time of cited deficiency Res.#4 had d/c from Health Care and transferred over to Assisted Living, but the MDS nurse proceeded with updating the resident care plan/profile to indicate the fall on 10/25/13 with interventions of appropriate level of assistance during transfers/ambulation. This update for Resident #4 was completed on 12/11/13.</p> <p>Resident #6 had the tab alarm added to care plan/profile on 12/11/13.</p> <p>2. The IDT completed a 100% audit of resident care plans to ensure 100% compliance with current interventions. The audit was completed by the MDS Nurse/DHS/ED. The audit was completed by 12/18/13. Upon completion of audits 100% compliance was achieved. The IDT will review all Incident Reports and Orders during daily CQI process and update care plans at the time of review.</p>	

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

TITLE

(X6) DATE

*Executive Director*

11/14/13

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

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F 280	Continued From page 1  Although the Minimum Data Set (MDS) Assessment dated 10/25/13, for Resident #4 revealed the facility assessed the resident as requiring the extensive assistance of one person (staff providing weight bearing support and physical assist for ambulation) and the Physical Therapy Discharge Summary dated 10/18/13 required a four (4) wheeled rolling walker with stand by assist (close enough to reach resident if assist needed) for ambulation, the Comprehensive Plan of Care, undated, with a print date of 08/13/13, and the current care plan, undated, printed 11/26/13 revealed no specific interventions to indicate the assistance required by staff for ambulation. Resident #4 sustained a fall on 10/25/13 at 11:45 AM while ambulating with an uncertified staff member who was not using a gait belt.  Also, after Resident #4 sustained the fall on 10/25/13, there was no documented evidence the Plan of Care was revised with specific interventions to prevent further falls.  In addition, Resident #6's care plan was not revised to include the tab alarm, although observation revealed the resident was utilizing the tab alarm in the wheelchair and in the recliner chair.  The findings include:  Review of the facility "Interdisciplinary Team Care Plan Guideline", revised 01/08, was to ensure appropriateness of services and communication that would meet residents' needs, severity or stability of conditions, impairment, disability, or	F 280	The MDS nurse or ADHS will update at time of review. If the MDS nurse or ADHS not available during the CQI process, then the DHS or medical records nurse will ensure timely update to care plan/profile.  3.All nurses were re-educated by the DHS/ADHS on the importance of accurate care plans. Completed by 12/26/13.  4.The Willows at Hamburg campus will audit 9 resident's care plans weekly x4 weeks, then 10 monthly x 3 months. These audits will be reviewed by the QA committee. The QA committee consisted of the Executive Director; Dir. of Health Services; Asst. Dir. of Health Services; Therapy Director; Plant Operations; Social Services; Activity Director; Food Services Dir.  The QA committee will move audits to a total of 10 resident care plans/profiles to be reviewed quarterly as long as 100% compliance continues to be achieved.	

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F 280	<p>Continued From page 2</p> <p>disease in accordance with state and federal guidelines. Further review, revealed the Comprehensive Care Plan was to be revised to reflect change in condition updates with each MDS Assessment.</p> <p>1. Review of Resident #4's medical record revealed diagnoses which included Depression, Osteoarthritis,, and Recurrent Colon Cancer. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/25/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) scored of fifteen (15) indicating no cognitive impairment. Further review of the MDS revealed the facility assessed Resident #4 to require a one (1) person assist for ambulation; indicating staff would provide weight bearing support and physical assist.</p> <p>Review of the Comprehensive Plan of Care, undated, with a printed date of August 2013, and the current copy of the care plan, undated, with a printed date of 11/26/13, revealed Resident #4 was care planned for the potential for falls. Review of the potential for falls care plan revealed a goal to be free of falls through November 2013. Interventions included staff were to provide the resident with assistance for transfers and amoulation and, assess for the correct use of the walker and wheelchair. Further review of the care plans revealed no documented evidence of specific approaches to indicate the type of staff assistance required by Resident #4 for ambulation.</p> <p>Review of the "Fall Circumstance Assessment and Intervention" form revealed Resident #4 sustained a fall on 10/25/13 at 11:45 AM. Review</p>	F 280	<p>The audits will look at physician orders to ensure that any new orders are transcribed onto the resident profile/care plan. The audits will be conducted by MDS nurse/Medical Records and/or DHS/ADHS.</p> <p>5. Allege Compliance</p>	1/3/14	

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F 280	<p>Continued From page 3</p> <p>of the Interdisciplinary Team (IDT) Review section of this form dated 10/28/13, revealed Resident #4 had stumbled while ambulating. Further review of the IDT Review section revealed it was determined staff would utilize a gait belt when ambulating Resident #4.</p> <p>Interview with Resident #4 on 11/25/13 at 2:20 PM, revealed the resident did not walk by himself/herself, staff used a gait belt and held on to the gait belt as he/she walked. Continued interview revealed he/she fell in October while walking in the hall with a walker without staff assistance. The resident indicated "a lady" who worked in the business office had volunteered to walk residents and did not hold on to her/him. Resident #4 stated she/he fell on to her/his back.</p> <p>Interview on 11/25/13 at 4:47 PM with the Business Office Manager (BOM), revealed she was not certified as a State Registered Nurse Aide (SRNA), and she had ambulated residents in the past without using a gait belt. However, she indicated she had not received education on how to ambulate residents. The BOM explained she was ambulating Resident #4 on 10/25/13, and was walking beside the resident and not using a gait belt. She stated, the resident fell backwards to the floor onto his/her back. Continued interview revealed there was an inservice the next day instructing staff not to ambulate residents unless the staff were certified as a SRNA.</p> <p>Interview on 11/26/13 at 11:00 AM with Registered Nurse (RN) #1 revealed she was assigned to the resident on 10/25/13; however, was at lunch at the time of the fall. Further interview, revealed she was told the BOM was</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>ambulating the resident at the time of the fall. She stated if the care plan stated assistance was required for ambulation, the person assisting with ambulation would need to be certified.</p> <p>Review of the Physical Therapy Discharge Summary, dated 10/18/13, revealed the resident could ambulate with a four (4) wheeled rolling walker with stand by assist (close enough to reach resident if assist needed).</p> <p>Interview on 11/26/13 at 11:30 AM and 12:30 PM with the Physical Therapist (PT), who completed the Physical Therapy Discharge Summary, revealed Resident #4 was to ambulate with trained nursing staff who used a gait belt to ensure safety. Interview with the Occupational Therapist (OT), who was present at the time of the interview with the PT, revealed only the licensed or certified staff were to use a gait belt which included nurses, SRNA's, OTs, and PTs.</p> <p>Interview on 11/26/13 at 1:00 PM, with the corporate Clinical Care Coordinator (CCC) revealed she had completed the 10/25/13 MDS and had coded Resident #4 as requiring weight bearing assistance with ambulation, meaning staff were to hold on to the resident to ambulate. She stated she had not completed the care plan with the printed date of August 2013; and the person who completed this care plan no longer worked at the facility. However, continued interview revealed she had completed the current care plan, which was undated and had a printed date of 11/26/13. She stated she had written an intervention for Resident #4 to have assistance to ambulate, and by that she meant for one person to assist. Further interview revealed the care plan should have been revised to be more</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>specific, such as, to state the resident needed a walker and assist of one with a gait belt. The CCC indicated the Care Plan should have been revised after the 10/25/13 fall to address this fall, and to add any interventions from the IDT meeting after the fall. The CCC reviewed the IDT Review dated 10/28/13, and stated the new intervention from the meeting was to ensure a gait belt was used and someone from the IDT meeting should have revised the care plan to include the intervention for the gait belt.</p> <p>Interview with the Director of Nursing (DON) on 11/26/13 at 12:30 PM, revealed care plans were updated by computer daily in the morning meeting if there were any changes/revisions indicated. The DON indicated there was no completion or revision date on the care plans; only the print date. The DON further stated, prior to the fall on 10/25/13, the care plan should have been revised to be more specific on how much assistance Resident #4 required and what devices were to be used to ambulate the resident. Continued interview revealed if Resident #4 was to be a "stand by" assist for ambulation, this should have been conveyed on the care plan; and, a certified person would need to provide the "stand by" assistance. Further interview revealed the care plan should have also been updated/revised after the 10/25/13 fall to address the fall. In addition, the DON stated the care plan should also have been updated/revised to include the intervention from the IDT Review for a gait belt to be used with ambulation.</p> <p>2. Review of Resident #6's clinical record revealed the facility admitted the resident on 07/17/13, with diagnoses which included Non-Alzheimer's Dementia and Parkinson's</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>Disease. Review of the Quarterly Minimum Data Set (MDS) dated 10/18/13, revealed the facility assessed the resident as having both short term and long term memory loss. Further review revealed the facility assessed the resident as sustaining one (1) fall since admission, entry, re-entry, or prior assessment.</p> <p>Review of the "Fall Circumstance Assessment and Intervention" form, revealed the resident sustained a fall on 11/15/13 at 11:00 AM. Continued review of the form revealed Resident #6 "slid" from the bed to the floor and did not sustain injury. Review of the form revealed the root cause of the fall was "decreased cognition". Review of the IDT Review section of the form dated 11/18/13, revealed the Director of Nursing (DON) had signed; however, under the "intervention update appropriate", or "change to" areas of the IDT Review section revealed nothing documented.</p> <p>Observation of Resident #6 on 11/25/13 at 4:30 PM, 5:02 PM and 5:45 PM, revealed the resident was sitting in a wheelchair with a tab alarm in place. Further observation on 11/26/13 at 9:40 AM and 10:00 AM revealed the resident was sitting in a recliner chair with the tab alarm in place.</p> <p>Review of the Comprehensive Plan of Care, undated, with printed dates of 10/28/13 and 11/25/13, revealed Resident #6 was at risk for falls related to a history of falling and poor safety awareness. Continued review of the care plan revealed several interventions listed; however, there was no documented evidence of an intervention for a tab alarm or evidence the fall on 11/15/13 was addressed.</p>	F 280			



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F 323	Continued From page 8 (4) wheeled rolling walker up to three hundred (300) feet with stand-by assist; however, the Comprehensive Plan of Care revealed no documented evidence of specific interventions to indicate the staff assistance required by the resident in regards to ambulation. On 10/25/13 at 11:45 AM, Resident #4 sustained a fall while ambulating with an uncertified staff member who was not using a gait belt. In addition, after Resident #4 sustained the fall on 10/25/13, there was no documented evidence the Plan of Care was revised with interventions to prevent further falls.  The findings include:  Review of the facility "Falls Management Program Guidelines", revised March 2008, revealed the facility strived to maintain a hazard free environment, mitigated fall risk factors and implemented preventative measures.  Review of Resident #4's medical record revealed the facility re-admitted the resident on 07/24/13, with diagnoses which included Depression, Osteoarthritis and Recurrent Colon Cancer. Review of the Nursing Admission Assessment and Data Collection form dated 07/24/13, revealed the resident was at risk for falls related to a history of falls and required assistance to transfer and ambulate.  Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/25/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated no cognitive impairment. Further review of this MDS revealed the facility assessed Resident #4 as requiring one (1)	F 323	100% of facility residents were reviewed to ensure that they were not affected by deficient practice. If deficient practice was identified, then the resident care plan/profile was updated immediately. The audit were completed by the MDS nurses/DHS/ED. Upon completion of audits, 100% compliance was achieved. The IDT will review all Incident Reports and Orders during daily CQI process and update care plans at the time of review. The MDS nurse or ADHS will update at time of review. If the MDS nurse or ADHS is not available during the CQI process, then the DHS or medical records will ensure timely update to care plan/profile. The IDT will review all Incident Reports and Orders during daily CQI process and update care plans at the time of review. Additionally, all Therapy Orders/ Recommendations will be reviewed to ensure added to care plan/profile. The MDS nurse or ADHS will update at time of review.		

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F 323	<p>Continued From page 9</p> <p>person assist for ambulation; with staff providing weight bearing support and physical assist.</p> <p>Review of the Comprehensive Plan of Care, undated, with a printed date of 08/13/13, and the current care plan, undated, with a printed date of 11/26/13, revealed the resident had the potential for falls with a goal to be free of falls through November 2013. Continue review of the potential for falls care plan revealed the interventions included staff were to provide assistance for transfers and ambulation; and, assess for correct use of the walker and wheelchair. Further review revealed no documented evidence of specific interventions to indicate the type of staff assistance Resident #4 required for ambulation.</p> <p>Review of the "Fall Circumstance Assessment and Intervention" form, revealed Resident #4 experienced a fall on 10/25/13 at 11:45 AM with no injury; however, he/she hit his/her head. Continued review revealed under the section entitled, "environmental inspection" it was noted "instruct staff use of gait belt". Review of the form revealed the Interdisciplinary Team (IDT) Review section, dated 10/28/13, stated Resident #4 had stumbled and indicated a gait belt was to be used when ambulating the resident.</p> <p>Interview with Resident #4 on 11/25/13 at 2:20 PM, revealed the resident did not walk by alone; and, staff used a gait belt when he/she was ambulating that they held on to. Resident #4 stated he/she fell in October while using a walker to walk in the hallway. The resident indicated "a lady" who worked in the business office had volunteered to walk with residents and was with him/her at the time of the fall. Resident #4 stated he/she stepped on the hem of his/her pants and</p>	F 323	<p>If the MDS Nurse or ADHS not available during the CQI process, then the DHS or medical records nurse will ensure timely update to care plan/profile.</p> <p>3. The Executive Director, Dir. of Health Services and Asst. Dir. of Health Services educated campus staff certified and non-certified regarding following the Resident Care Plan with regards to level of assistance required. Education of all current campus staff was completed by December 26, 2013. This education was related to certified and non-certified staff providing assistance to residents. The education did relate to facility policy and procedure regarding transfers and ambulation.</p> <p>4. The campus will audit 10 residents weekly x 4 weeks. If 100% compliance achieved during this period then the campus will complete 10 resident care plan/profile audits monthly x 3 months. If 100% compliance achieved, then IDT</p>	
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F 323	<p>Continued From page 10</p> <p>fell on to his/her back. According to Resident #4, the "lady" who was walking with him/her did not hold on to him/her.</p> <p>Interview on 11/25/13 at 4:47 PM, with the Business Office Manager (BOM), revealed she was not certified as a State Registered Nurse Aide (SRNA). She stated she had ambulated residents in the past and did not use a gait belt. She indicated she had not received education on ambulating with residents to ensure the residents were safe. The BOM stated she was ambulating Resident #4 on 10/25/13 and walking beside the resident. She stated she was not using a gait belt. According to the BOM, the resident fell backwards to the floor. The BOM stated there an inservice was held the next day instructing staff not to ambulate residents unless they were certified as a SRNA.</p> <p>Interview on 11/26/13 at 11:00 AM, with Registered Nurse (RN) #1 revealed she was the nurse assigned to the resident on 10/25/13, at the time of the fall. She stated she was at lunch at the time of the fall, and was told the BOM was ambulating the resident when he/she fell. She stated if the care plan stated assistance was needed for ambulation, the person assisting with ambulation should be certified.</p> <p>Review of the Physical Therapy Discharge Summary dated 10/18/13, revealed Resident #4 could ambulate with a four (4) wheeled rolling walker up to three hundred (300) feet with "stand by" assist which meant staff would be close enough to reach the resident if assist was needed.</p> <p>Interview on 11/26/13 at 11:30 AM and 12:30 PM,</p>	F 323	<p>will review during QA process to move audits to 10 resident specific care plans/profiles to be reviewed quarterly as long 100% compliance continues to be achieved. The audits will look at physician orders to ensure that any new orders are transcribed onto the resident profile/care plan. The facility will also conduct weekly audits to observe for proper level of assistance and appropriate safe environmental supervision. The audit will monitor environmental for safety; observe transfers and ambulations and providing resident assistance to ensure that all care plan interventions are being followed and safety standards being practiced to ensure safe environment. The audits will observe 10 residents weekly for 4 weeks and then 10 residents monthly for 3 months and then quarterly if facility maintains 100% compliance. The QA committee will review all audits during the monthly QA meetings.</p>		

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

PRINTED: 12/11/2013  
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 11/26/2013
NAME OF PROVIDER OR SUPPLIER  THE WILLOWS AT HAMBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 2531 OLD ROSEBUD ROAD LEXINGTON, KY 40509		
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F 323	<p>Continued From page 11</p> <p>with the Physical Therapist (PT) who completed the Physical Therapy Discharge Summary revealed Resident #4 only trained nursing staff should ambulate Resident #4 with the use of a gait belt. He stated he conveyed information verbally to the nursing staff on the unit related to how residents were to be transferred and ambulated. The PT stated his Physical Therapy Evaluations were placed in the computer also. Interview with the Occupational Therapist (OT), who was present in the above Interview with the PT, revealed only certified or licensed staff should use a gait belt. The OT stated this would include nurses, SRNA's, OT and PT staff.</p> <p>Interview with the Director of Rehabilitation on 11/26/13 at 12:40 PM, revealed if a resident required "stand by" assist, they would have the potential to "bobble" due to poor balance; and, a gait belt would be needed to ensure safety when ambulating the resident.</p> <p>Interview on 11/26/13 at 1:00 PM, with the corporate Clinical Care Coordinator (CCC) revealed she had completed the Quarterly 10/25/13 MDS Assessment. She stated she coded Resident #4's ambulation as requiring weight bearing assistance; meaning staff would hold on to the resident to ambulate. The CCC stated she had completed the current care plan which was undated and printed on 11/26/13. Continued interview, revealed Resident #4 required assistance to ambulate, and by that she meant a one (1) person assist. She stated the care plan should have been more specific to indicate the resident's need for a walker and assist of one (1) with use of a gait belt. The CCC stated the care plan should have been revised after the 10/25/13 fall to address that fall; and, to</p>	F 323	<p>The audits will be conducted by MDS nurse/Medical Records and/or DHS/ADHS.</p> <p>5. Allege Compliance</p>	1/3/14	

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F 323	Continued From page 12 add any interventions from the IDT meeting which was held after the fall. The CCC reviewed the IDT Review dated 10/28/13, and stated the new intervention from the meeting was to use a gait belt when Resident #4 ambulated. She indicated someone from the IDT meeting should have added the intervention for the gait belt to the care plan.  Interview with the Director of Nursing (DON) on 11/26/13 at 12:30 PM, revealed care plans were updated daily in the facility's "morning meeting" if revisions were necessary. She stated these updates were made by computer. According to the DON, care plans did not have a completion or revision date; the only date they contained was the date printed. The DON stated, prior to Resident #4's fall on 10/25/13, the care plan should have been specific on how much assistance the resident required and what devices were to be used to ambulate the resident. Continued interview revealed if Resident #4 was to be "stand by" assist for ambulation, this should have been conveyed on the care plan; and, a certified person would need to assist the resident with ambulation. The DON further stated the care plan should have been updated after the 10/25/13 fall to address the fall and, to add the intervention from the IDT Review for the gait belt to be used when Resident #4 ambulated.	F 323			