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

PRINTED: 09/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185470		09/12/2013

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

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F 000	INITIAL COMMENTS A Standard Re-certification Survey was conducted on 09/10/13 through 09/13/13. Deficiencies were cited with the highest scope and severity of an "E".	F 000	DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES AND DISPUTES THE DEFICIENCIES STATED IN THE 2567. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN THE 2567 IN SUPPORT OF THE ALLEGED DEFECIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF MULTIPLE INTERVIEWS, THE TRAINING AND EXPERIENCE OF STAFF INVOLVED, THE TIMING SEQUENCE OF EVENTS AND CONTACT WITH HEALTH CARE PROFESSIONALS AND THE CARE AND SUPREVISION PROVIDED TO THE RESIDENTS. THE FACILITY PRESENTED CONTRARY EVIDENCE DURING THE SURVEY ITSELF WHICH WAS NOT ACKNOWLEDGED BY THE CABINET AND WILL DO SO THROUGH THE DISPUTE RESOLUTION PROCESS AS WELL.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure Physician Orders were followed for one (1) unsampled resident during a medication pass. Unsampled Resident #A was administered medications through a Gastrostomy (G-tube) tube with a Physician's order to administer medications by mouth. The findings include: Review of the facility's policy, titled Enteral Tube Medication Administration dated 02/01/10, revealed the prescriber (physician) orders the route of administration for new medication orders. Further review of the facility's policy, revealed for G-tube administration, the powder from each medications should be mixed with water before administration. Further review revealed crushed medications were not to be mixed together and should be administered separately to avoid interaction and clumping. Continued review revealed there should be at least a five (5) milliliter flush of water between each medication	F 281	F 281 1. A Physicians order was obtained on 10/7/13 for resident #A to administer	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Pullins | TITLE: Executive Director | (X6) DATE: 10/7/13

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 281	Continued From page 1 to avoid physical interaction of the medications. Review of Unsampled #A's medical record revealed, the facility admitted the resident on 05/20/13 with diagnoses which included Cerebreal Vascular Accident, Hemiparesis, Dysphagia, Emphysema and diabetes. Review of the Physician's orders revealed Unsampled Resident #A was ordered to have been administered medications per oral route. Further review of the Medication Administration Record and Physician's orders revealed no documented evidence found a physician had ordered the medications to be given together via the G-tube without a fluid flush between the medications. Observation during a medication pass, on 09/11/13 at 9:15 AM, revealed Licensed Practical Nurse (LPN) #2 administered medications to Unsampled Resident #A via a G-tube. Further observation revealed LPN #2 administered all Unsampled Resident #A's medications together without prior dilution with water and without a fluid flush between each medication. Interview with LPN #2, on 09/11/13 at 9:56 AM, revealed she normally administered Unsampled Resident A's medications through the G-tube,per the family's request. Further interview revealed she was not sure if there was a Physician's order to administer the medications per the G-tube. Further interview revealed the Physician ordered the route a medication was to be administered and she should have obtained an order from the Physician to administer the medications per the G-tube. Further interview revealed she normally administered all the crushed medications	F 281	compatable medications together via Gastrostomy tube. Although his G-Tube was temporarily non-patent the resident had no significant adverse affect. 2. All other residents with gastrostomy tubes (G/T) were audited by ADHS on 10/7/13 to assure physicians order to administer medications via correct route. 3. Nurses received in-service education on October 3, 14, and 17, 2013 conducted by the Director of Health Services (DHS)/Assistant Director of Health Services (ADHS) /Medical Records Nurse (MRC Nurse) regarding correct procedure for G/T medication administration with an emphasis on verifying the "5 rights" before administering medications and verifying medications are compatable to administer together Systemic change: Medication administration records will be color coded for all non po routes to alert nurse. 4. Residents receiving medications via G/Tube will be audited by the DHS/ADHS/MRC Nurse 5 x per week x 3 months. The DHS/ADHS/MRC Nurse will review the results of the audits weekly as part of the morning clinical care meeting in order to determine where additional in-service education or corrective actions are	

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F 281	Continued From page 2 together and should have diluted the powder with water prior to administration. Further interview revealed she should have had a Physician's order to administer the medication together. Interview with the Assistant Director of Human Services, on 09/12/13 at 3:39 PM, revealed a Physician's order was required to administer the medications together and to administer the medications via the G-tube. Further interview revealed the nurse was responsible to contact the Physician to obtain an order to administer the medications together and via the G-tube per the facility's policy.	F 281	needed. The results of these reviews conducted by DHS/ADHS/MRC Nurse will be discussed in the monthly QA (which is attended by Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) x 3 months. Based on QA discussions other corrective actions may be initiated as necessary. 5. Date October 17, 2013	10-17-13
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322	F322 1. A Physicians order was obtained on 10/7/13 for resident #A to administer compatible medications together via Gastrostomy tube. 2. All other residents with gastrostomy tubes (G/T) were audited by ADHS on 10/7/13 to ensure that physicians orders clearly indicated the physician ordered route. No additional concerns were noted. 3. Nurses received in-service education on October 3, 14, and 17, 2013 conducted by the Director of Health Services (DHS)/Assistant Director of Health Services (ADHS) /Medical Records Nurse (MRC Nurse) regarding correct procedure for G/T medication administration with an emphasis on verifying the "5 rights"	

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F 322	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to minimize the potential for complications from feeding tubes for one (1) of three (3) residents (Unsampled Resident #A) with a Gastrostomy Tube (G-tube). The facility failed to ensure the crushed medications were diluted in fluids prior to placing medications into the G-tube syringe for administration. Additionally, the facility failed to ensure medications were administered separately with a fluid flush between medications. The findings include: Review of the facility's policy titled, Enteral Tube Medication Administration, dated 02/01/10, revealed the powder from each medications should be mixed with water before administration. Further review revealed crushed medications were not to be mixed together and should be administered separately to avoid interaction and clumping. Continued review revealed there should be at least a five (5) milliliter flush of water between each medication to avoid physical interaction of the medications. Observation during a medication pass, on 09/11/13 at 9:15 AM, revealed Licensed Practical Nurse (LPN) #2 obtained twelve (12) tablet formed medications for Unsampled Resident #A, crushed all twelve (12) tablets together, and entered Unsampled Resident #A's room. LPN #2 prepared resident for medication administration, verified placement of G-tube, flushed G-tube, connected administration syringe to resident, administered other liquid form medications, filled	F 322	before administering medications and verifying medications are compatable to administer together Systemic change: Medication administration records will be color coded for all non po routes to alert nurse. 4. Residents receiving medications via G/Tube will be audited by the DHS/ADHS/MRC Nurse 5 x per week x 3 months. The DHS/ADHS/MRC Nurse will review the results of the audits weekly as part of the morning clinical care meeting in order to determine where additional in-service education or corrective actions are needed. The results of these reviews conducted by DHS/ADHS/MRC Nurse will be discussed in the monthly QA (which is attended by Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) x 3 months. Based on QA discussions other corrective actions may be initiated as necessary. 5. Date October 17, 2013 10-17-13 F323 1. The items identified for Resident # 7 were remove and safely secured by the	

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F 322	Continued From page 4 administration syringe with approximately 50 milliliter of water and added all crushed medications to syringe without prior diluting powder. Administration syringe and tubing became occluded and stopped flowing. LPN #2 attempted to manipulate tubing and syringe to dislodge occlusion unsuccessfully. LPN #2 then left room to locate a "G-tube declogger". At 9:51 AM, LPN #2 returned to Unsampled Resident #A's room and was able to administer same medications without the use of the G-tube declogger. Interview with LPN #2, on 09/11/13 at 9:56 AM, revealed she normally administered Unsampled Resident A's medications through the G-tube, per the family's request. Further interview revealed she normally administered all the crushed medications together and should have diluted the powder with water prior to administration. Further interview revealed she should have had a Physician's order to administer the medication together. Interview with the Assistant Director of Human Services, on 09/12/13 at 3:39 PM, revealed a Physician's order was required to administer the medications combined together via the G-tube. Further interview revealed the nurse was responsible to contact the Physician to obtain an order to administer the medications together and via the G-tube. Continued interview revealed the nurse should have diluted the medications with water prior to administration to decrease the risk of complications with the G-tube, per the facility's policy.	F 322	ADHS on 9-12-13. The ADHS discussed with Resident # 7 the rationale behind safely securing these items and that the items were available to her upon asking. 2. All other resident accessible areas were observed by the DHS/ED/ADHS on 9/12/13 to assure all hazardous items were safely secured. Residents have been made aware of the rationale of storing potential hazardous items in a secure area and that these items are available upon request. 3. All staff received in-service education on October 3, 14, and 17, 2013 conducted by the Director of Health Services (DHS)/Assistant Director of Health Services (ADHS) /Medical Records Nurse (MRC Nurse)/Dietician/ED on the importance of assuring all hazardous items are safely secured. Systemic change: Additionally, Resident Ambassadors (department leaders) will conduct ambassador audits weekly as part of the family call program. 4. The QA committee, made up of the Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) will review the	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 5 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, interview and review of the facility's policy, it was determined the facility failed to ensure that the resident environment remained as free of accident hazards as was possible. Observation of a resident's room, revealed medications and acetone nail polish remover in the bathroom accessible to other residents. The findings include: Review of the facility's policy titled, Bedside Storage of Medications dated 09/17/12, revealed a written order by the physician for storage of medication should be present in the resident's medical record. Further review revealed storage of medications should be in a manner that prevented access by other residents. Review of the Material Safety Data Sheet (MSDS) for Acetone Nail Polish Remover, supplied by the facility, revealed nail polish remover is extremely flammable and its vapors form explosive mixtures with air. Nail polish remover is dangerous when exposed to heat, sparks, flame or oxidants. Further review of the MSDS, revealed the potential health hazards were gastroenteric	F 323	results of all the ambassador audits for potentially hazardous materials monthly for three months. Based on QA discussions other corrective actions may be initiated as necessary. 5. Date October 17, 2013 10-17-13 F367 1. On 9-12-13 Resident # 3 was provided with a mechanical soft diet per physicians order by the dietary manager. 2. All other residents tray cards were verified with the meal provided by the Dietary Director on 9-12-13 to assure all residents were provided with the diet as ordered. 3. All dietary staff received in-service education conducted by the Home Office Dining Support and the Dietician on October 3, 2013 and October 8, 2013 on the policy and procedure to assure residents receive the correct diet as ordered. Systemic change: A tool titled the Resident listing Report, which lists each residents individual diet	

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F 323	Continued From page 6 irritation, narcosis and injury to the kidneys and liver, headache, nausea, confusion, drowsiness, convulsions, and coma. Observation of a semi-private room shared by Resident #7 and Resident #8 during initial tour on 09/10/13, revealed acetone nail polish remover and Phillips Stool Softener Tablets in the shared bathroom on an uncover, unsecured plastic shelving unit accessible to all residents. Record review revealed, the facility admitted Resident #8 on 01/12/13 with diagnoses which included Anemia, Increased Lipids, Coronary Artery Disease, hypertension and Alzheimer's disease. Review of Resident #8's Admission MDS, dated 01/19/13, revealed the resident was assessed by the facility to have a Brief Interview for Mental Status score of 4/15, indicating cognitively impaired. Record review revealed, the facility admitted Resident #7 on 01/03/13 with diagnoses which included Hypertension, Diabetes, Hyperlipidemia, Gout, Osteoporosis and Osteoarthritis. Review of Resident #7's Quarterly Minimum Data Set (MDS), dated 07/10/13, revealed the resident was assessed by the facility to have a Brief Interview for Mental Status score of 15/15. Interview with Registered Nurse (RN) #2 on 09/12/13 at 2:51 PM, revealed residents were not permitted to store medications in their rooms. Further interview revealed medications should be locked in the medication room. Interview with the Assistant Director of Human Services (ADNS) on 09/12/13 at 4:00 PM, revealed medications should be kept in the	F 323	order, will be made available and will be updated as diet changes occur. 4. DietaryManager/ED/DHS/ ADHS/Meal Manager (MM) will audit 6 meals weekly x 3 months to assure residents recieve the correct diet as ordered. The QA committee, made up of the Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) will review results of all audits monthly. Based on QA discussions other corrective actions may be initiated as necessary. 5. Date October 17, 2013 10-17-13 F371 1. The items identified were immediately discarded by the Director of Food Services on 9-12-13. No residents were identified as having been affected.	

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F 323	Continued From page 7 Medication room. Further interview revealed the facility did not have a specific policy for nail polish remover, however did feel that it could potentially be hazardous for cognitively impaired residents. Continued interview revealed the facility had twenty (20) residents cognitively impaired with dementia. Further interview revealed the facility did not have any residents with wandering tendencies.	F 323	2. All residents have the potential to be affected by the deficeint practice. 3. Dietary staff received in-service education conducted by the Home Office Dining Support and the Dietician on October 3, 2013 and October 8, 2013 on the policy and procedure for proper food storage of open items. 4. The Director of Food Services will audit the walk in refrigerator 3 x week x 3 months to assure all out dated food is discarded. The QA committee, made up of the Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) will review results of all audits monthly. Based on QA discussions other corrective actions may be initiated as necessary.	
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure one (1) of thirteen (13) residents, Resident #3, received foods in the appropriate form as prescribed by the physician/ dietician. Resident #3's meal card indicated a mechanically soft diet; however, observation revealed a regular textured diet was served with no waiver in place. The finding includes: Record review revealed the facility admitted Resident #3 on 12/13/12 with diagnosis which included Heart Murmur, Type I Diabetes, Osteoarthritis, Hypertension, Pernicious Anemia, Hypothyroidism, Bladder Prolapse/Incontinence and Macular Degeneration. Review of Resident #3's Minimum Data Set (MDS), dated 07/06/13, revealed Resident's #3's Brief Interview for Mental Status (BIMS), had a score of fifteen (15),	F 367	5. Date October 17, 2013 10.17.13	

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F 367	Continued From page 8 which indicated the resident was cognitively intact. Further record review revealed the resident was sent to the hospital due to hypoglycemia, anemia, and a small bowel impaction. Resident #3 was readmitted to the facility on 07/23/13. At this time, the resident's nutrition progress notes revealed his/her diet was changed to a mechanical soft diet; due to resident stating he/she had a difficult time chewing regular texture foods. Review of Resident #3's Physician's order, dated 07/31/13, indicated the resident's diet was changed to mechanical soft, consistent or controlled carbohydrate, and no added salt diet. Review of Resident #3's care plan, dated 8/13, revealed the resident reported to family he/she was not getting foods of proper texture. The care plan further revealed staff would ask resident if he/she would like anything else before leaving resident's room. Interview with Resident #3, on 09/10/13 at 3:00 PM, revealed Resident #3 was dissatisfied with the meals he/she was served. Resident #3 stated the food was, "not for old people". Resident #3 explained he/she was on a mechanically soft diet and reported the foods he/she received was too difficult to chew. Observation, on 09/10/13 at 6:10 PM, revealed Resident #3 received dinner in his/her room. Resident #3 was served Crispy Chopped Chicken Salad, with whipped cream apricots, and tomato bisque. Resident #3 was given coffee and fortified shake to drink. Further observation revealed the resident's meal ticket read he/she was on mechanically soft and fortified shake with every meal. Resident #3 was observed to eat	F 367	F441 1. Res. #2, #4. and #12 had no adverse affects related to the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. All nursing staff including CRCA #2 and LPN #5 received in-service education on October 3, 14, and 17, 2013 conducted by the Director of Health Services (DHS)/Assistant Director of Health Services (ADHS) /Medical Records Nurse (MRC Nurse) on the facility infection control policy with an emphasis on washing of hands when removing soiled gloves, prior to doning clean gloves and any time they come in contact with contaminated items. 4. Handwashing Compliance audits will be conducted 3 x week x 3 months (The audits will include observations for dressing changes and peri care) by the DHS/ADHS/Medical Record nurse/and night shift charge nurse. The audits will monitor for proper handwashing procedure during	

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F 367	Continued From page 9 Ritz crackers, already located in his/her room, and the soup only. Interview with the Director of Food Service, on 09/10/13 at 6:30 PM, revealed the kitchen staff would receive meal ticket orders from a Physician's order. He further revealed the dietician would make a recommendation for resident's meal preferences and/or suggests changes in a resident's diet and nursing staff would give the recommendations to the Physician to sign the order. The Director of Food Service added that once the order was signed by the Physician, then the diet confirmation would generate the resident's meal ticket. The Director of Food Service reported that residents who were on mechanically soft texture diets did not receive the crispy chopped chicken salad. Instead, residents on the mechanically soft diet received the chicken sandwich for their meal. The Director of Food Service reported that if a resident received the crispy chopped chicken salad, then he/she would have been conferenced on his/her food choice and a waiver would have been signed. The Director of Food Service indicated he was not sure if the resident was conferenced on his/her meal choice and reported a signed waiver could not be located. The Director of Food Service concluded by stating he expected his staff to follow the resident's menu ticket/diet order by the Physician/Dietician. Interview with the Facility's Dietician, on 09/12/13 at 7:15 PM, revealed she could not locate a policy in regards to residents "Therapeutic diets". The dietician explained regular diets and mechanically soft diets were different. She stated residents on mechanically soft diets should not receive a regular diet due to difficulty in residents' ability to	F 367	resident care which could include pericare and dressing changes. The QA committee, made up of the Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) will review results of all audits monthly. Based on QA discussions other corrective actions may be initiated as necessary. 5. Date October 17, 2013 10-17-13 F520 1. It is is the mission of this facility's Quality Assessment and Assurance Committee to develop and implement a plan of action to assure the facility provides accepted standards of clinical practice to assure residents receive their medications as ordered by physician. As a result of the deficient practice Resident A's G-Tube was temporarily non-patent the resident had no significant adverse affect. No other residents were identified as having been affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185470		09/12/2013
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 367	Continued From page 10 chew. She further stated the mechanical soft diet helps residents chew better. The Dietician stated if the resident did not receive his/her meals as ordered, then that would impact a resident's nutritional status because they would not eat. She further revealed it was her expectation for the meal plan to be followed as ordered.	F 367	2. All residents have the potential to be affected by the deficient practice. 3. The ED and DHS were inserviced by the Clinical Support Nurse on September 13, 2013 on the regulatory requirements of a QA committee with an emphasis of a thorough QA meeting. The focus of the next 6 months of QA meeting will be on the review of the audit results and necessary changes/actions as a result of the findings of the audits as well as any other opportunities noted by the committee.	
F 371 SS=E	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 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 facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, on 09/10/13, revealed a food item stored past the proper use by date. A plastic container with turkey parts was stored in the refrigerator with a date of 08/28/13. The findings include: A review of the facility policy: " Date Marking", 2009 Armstrong Nutrition Management, revealed all prepared foods that are stored will be properly dated to ensure food safety. Review of the	F 371	4.The QA committee, made up of the Medical Director, Executive Director (ED), Director of Nursing (DHS), Assistant Director of Nursing (ADHS), Medical Record Nurse (MRC Nurse) will review results of all audits monthly. Based on QA discussions other corrective actions may be initiated as necessary. . Additionally, member of the Corporate Compliance Department will attend the next 3 months of QA meetings to review audits and	

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F 371	Continued From page 11 Procedure section revealed Refrigerated Items that are open must be used or discarded within 7 days. Date marking for discard ensures the safety of the food. Observation, on 09/10/13 at 10:30 AM, of the walk in refrigerator revealed a plastic container with turkey parts dated 08/28/13. The Director of Food Services removed the container from the refrigerator. Interview with the Director of Food Services (DFS), on 09/10/13 at 10:30 AM and on 09/12/13 at 5:53 PM, revealed the container with turkey should not have been in the refrigerator because the date was past the interval they have for which it could be used. The DFS further stated it was a food safety issue and the item should have been discarded. He stated the policy states they had a seven (7) day period to store open items that were not leftovers. He further stated had the food been served there was a potential for residents to get sick because it was past the seven (7) day food storage period.	F 371	findings with the ED, DHS and QA members. 5. Date: October 17, 2013	10/17/13
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		

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 09/12/2013
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 441	Continued From page 12 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 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 establish and maintain an Infection Control program to prevent the development and transmission of disease and infection for three (3) of thirteen (13) sampled residents (Residents: #2, #4, and #12). Observation of wound care treatments, for Residents # 2 and #4, revealed staff failed to clean hands after removing potentially	F 441		

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	185470		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 contaminated gloves prior to donning a new pair of gloves. In addition, staff providing care to Resident #12 performed bowel care and removed soiled linens failed to clean his/her hands after removing potentially contaminated gloves prior to donning a new pair of gloves and touching clean surfaces. The findings include: Review of the facility's policy "Guidelines for Handwashing" Policy, dated 10/2004, revealed Handwashing is the single most important factor in preventing transmission of infections. Review of the policy's Procedure section revealed health care workers shall wash hands at times such as: after removing gloves worn for direct contact with excretions or secretions, mucous membranes, grossly soiled linens. Review of the facility's policy: "General Guidelines for Dressing Changes", dated December 2009, revealed the purpose of the policy was to ensure measures were taken to promote and maintain skin integrity while maintaining standard measures that minimized / controlled contamination. Review of the Procedure section revealed after removing the soiled dressing staff were to dispose of the gloves worn, wash hands, and then put on a second pair of gloves. In addition, after completing the wound treatment staff were to remove gloves and wash hands with soap and water. 1. Review of Resident # 12's medical record revealed the resident was admitted by the facility on 08/21/13 with diagnoses which included Lung Cancer, Diabetes Type II, Chronic Obstruction	F 441		

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F 441	Continued From page 14 Pulmonary Disease (COPD), Hypertension, and Urinary Tract Infection (UTI). Review of Resident # 12's Admission Minimum Daily Data Set (MDS), dated 08/28/13, revealed the resident was severely cognitively impaired. Further review of the MDS revealed the facility had assessed the resident as being frequently incontinent of both bowel and bladder. Review of Resident #12's plan of care for Bowel and Bladder, no date, revealed the resident was care planned for incontinence related to weakness, COPD, and recent hospitalization for Urinary Tract Infection (UTI). The planned interventions included facility staff were to check for incontinence and provide pericare after each incontinent episode. Observation, on 09/12/13 at 2:15 PM, of bowel incontinence care by Certified Resident Care Associate (CRCA) # 2 revealed Resident # 12 had a bowel movement and had soiled his/her briefs and the linens. Further observation revealed after CRCA #2 provided bowel care and removed the soiled linens, he/she changed gloves and proceeded to apply clean linens to the bed. CRCA #2 then removed his/her gloves, washed hands, put on new gloves and dressed the resident. Interview, on 09/12/13 at 2:42 PM, with CRCA #2 revealed when you completed bowel incontinence care she should have washed her hands and then put on clean gloves before she put clean sheets on the bed. The CRCA further stated it was an infection control issue and she was nervous.	F 441		

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F 441	Continued From page 15 Interview, on 09/12/13 at 5:33 PM, with the Infection Control Nurse (ICN) revealed after bowel care was completed, on Resident #12, the aide was supposed to wash her hands before putting on gloves. The ICN stated the CRCA should not have only put on the gloves before touching the clean sheets. The ICN further stated the bowel area was considered a dirty area, and potentially contaminated, and then the aide moved to a clean surface. 2. Review of Resident # 2's medical record revealed the resident was admitted by the facility on 01/23/13 with diagnoses which included Liver Cirrhosis (consequence of chronic liver disease), Hepatic Encephalopathy (disorder of mental activity, neuromuscular function and consciousness that occurs as a result of either chronic or acute liver failure), Malignant Ascites (formation of fluids and cancer cells in the abdominal cavity), Debility, Right Sided Hemiparesis (weakness on one side of body), Generalized Weakness, and Chronic Back Pain. Review of Resident #2's Quarterly MDS, dated 07/16/13, revealed the resident was moderately cognitively impaired. Further review of the MDS revealed the facility assessed the resident had a Stage II Pressure Ulcer area. Review of Resident #2's monthly Physician orders for September 2013 revealed wound care orders to clean the wound to the coccyx with normal saline pat dry, apply santyl ointment to the wound bed cover with gauze and secure with tape daily. In addition, the monthly orders included skin-prep to be applied topically to both heels every shift and Vasolex/Xenaderm 60 gm Ointment applied to legs/arms twice a day. Observation of wound care and skin treatment by Licensed Practical Nurse (LPN) #5, on 09/11/13	F 441		

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F 441	Continued From page 16 at 9:49 AM, revealed after cleaning the wound with Normal Saline the nurse removed her gloves washed her hands and re-gloved. Further observation revealed after the the LPN applied Santyl Ointment to the wound site and the new dressing, she changed gloves only before applying skin prep to the heals and then Vasolex/Xenaderm Ointment to the arms and legs. After the nurse completed the procedures she washed her hands upon the completion of care. Interview with LPN #5, on 09/11/13 at 10:07 AM, revealed staff were supposed to wash hands if the hand area was soiled. The LPN stated after cleaning the wound with normal saline she changed gloves and washed her hands. However, since she considered the wound site clean the LPN stated she did not need to wash her hands after completing the wound care. The LPN further stated she did not consider the gloves dirty so she only changed gloves when she applied the Vasolex skin treatment to the resident's arms/legs and skin prep to the residents heels. Interview with the ICN, on 09/12/13 at 5:33 PM, revealed after the nurse completed the wound care she should have washed her hands after removing her gloves prior to donning new gloves to begin another procedure. The ICN stated because the nurse touched the wound site to apply the Santyl treatment the nurse should have washed her hands, after she completed the wound care. The ICN further stated because of possible organisms being present at the wound site there was the potential for cross contamination when performing different procedures. She stated it was an infection control issue and the wound policy stated after completing wound care hands were to be	F 441		

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	185470		09/12/2013

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F 441	Continued From page 17 washed. 3. Review of Resident #4's medical record revealed the facility admitted Resident #4 on 08/14/13 with diagnoses which included Venous Statis Ulcers, Atrial Fibrillation, Diabetes, Chronic Kidney Disease, Anemia and Coronary Artery Disease. Review of Resident #4's Admission MDS, dated 08/21/13, revealed a Brief Interview for Mental Status (BIMS) score of 15. Further review revealed Resident #4 was assessed upon admission to have four (4) Venous and/or Arterial Ulcers. Review of Resident #4's monthly Physician orders for September 2013, revealed wound care orders to clean the wounds to the bilateral lower legs two times each day from the knee down with Normal Saline, pat dry, apply a mixture of triple antibiotic cream and hydrocortisone cream, cover with Vaseline gauze and ABD pad over wounds and cover with Kerlex wrap. Additionally, Granulex was to be applied to bilateral feet and heels then wrapped with Kerlex. Observation of wound care and skin treatment by Registered Nurse (RN) #1, on 09/10/13 at 5:45 PM, revealed after removing the soiled dressing from the Left leg, RN #1 changed her gloves, cleansed with Normal Saline, applied mixture of antibiotic cream and Hydrocortisone cream, changed gloves, applied Vaseline dressing, changed gloves, applied ABD pad, applied Granulex to feet and heels, then wrapped with Kerlex wrap. After completing wound care to the left leg, RN washed hands, donned gloves and repeated above procedure for the right leg. Interview with RN #1, on 09/11/13 at 5:50 PM, revealed during wound care, staff should remove gloves, wash hands and don new gloves anytime during the procedure when going from a "dirty" area such as the soiled dressing, to a clean area	F 441		

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	185470		09/12/2013

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F 441	Continued From page 18 such as applying the treatments and redressing the wound. RN #1 stated this could result in cross contamination and be an infection control issue. Further interview revealed RN #4 stated she was nervous during the observation. Interview with the Infection control Nurse (ICN), on 09/12/13 at 5:33 PM, revealed the nurse should have removed gloves and wash hands after removing soiled dressing and donned new gloves prior to continuing procedure due to the possibility of cross contamination of the new dressing.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520		

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F 520	Continued From page 19 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and review of the facility's Plan of Correction, it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) program that developed and implemented plans to correct quality deficiencies. This was evident by repeated deficiencies related to the facility's failure to ensure services were provided according to accepted standards of clinical practice. (Refer to F281) The findings include: Review of the facility's Plan of Correction (POC) signed by the Executive Director (ED) on 03/11/13, revealed the Director of Human Services (DHS) initiated in-service education of all licensed staff regarding the specific medication administration procedures to include: the correct time, correct dose, correct route, correct medication and resident identification prior to administering the medication. Further review of the Plan of Correction revealed the facility should be conducting on-going audits related to medication administration. Review of the facility's policy titled "Enteral Tube Medication Administration" dated 02/01/10, revealed medications are prescribed by the physician and was to include the route the medication is intended to be administered. Further review of the facility's policy, revealed medications should not be combined and each medication should be diluted with water prior to	F 520		

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 09/12/2013
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 520	Continued From page 20 administration via the G-tube. Observation during a medication pass, on 09/11/13 at 9:15 AM, revealed Licensed Practical Nurse (LPN) #2 obtained twelve (12) tablet formed medications for Unsampled Resident #A, crushed all twelve (12) tablets together, and entered Unsampled Resident #A's room. LPN #2 prepared resident for medication administration, verified placement of G-tube, flushed G-tube, connected administration syringe to resident, administered other liquid form medications, filled administration syringe with approximately 50 milliliter of water and added all crushed medications to syringe without prior diluting powder. Administration syringe and tubing became occluded and stopped flowing. LPN #2 attempted to manipulate tubing and syringe to dislodge occlusion unsuccessfully. LPN #2 then left room to locate a "G-tube declogger". At 9:51 AM, LPN #2 returned to Unsampled Resident #A's room and was able to administer same medications without the use of the G-tube declogger. Review of Unsampled #A's medical record revealed, the facility admitted the resident on 05/20/13 with diagnoses which included Cerebral Vascular Accident, Hemiparesis, Dysphagia, Emphysema,diabetes and Gastrostomy tube. Review of the physician's orders revealed Unsampled Resident #A was ordered to have been administered medications per oral route. Interview with the Assistant Director of Nursing (ADNS), on 09/12/13 at 3:39 PM, revealed her expectations were the nurse should have obtained a physicians order to administer the	F 520		

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	185470		09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 21 medications via G-tube and to administer the medications combined per the facility's policy. Interview with the Director of Nursing (DON), on 09/12/13 at 8:20 AM, revealed the physician's ordered stated per the oral route and the nurse should have obtained an order to administer via the G-tube. Interview with the Exective Director (ED), on 09/12/13 at 5:52 PM, revealed new nursing staff were provided preceptors. Further interview revealed pharmacy reviewed all medication errors and track and trend for similarities. Further interview revealed all medication error were evaluated. Continued interview revealed training and education were provided to the staff after errors were evaluated and as needed. He further stated the audits were focused on giving the correct medication to the correct resident and not on the medication given by the correct route.	F 520		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE WILLOWS AT HAMBURG B. WING	(X3) DATE SURVEY COMPLETED
	185470		09/10/2013

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K 000	INITIAL COMMENTS	K 000		
	CFR: 42 CFR 483.70 (a)			
	BUILDING: 01			
	PLAN APPROVAL: 6/13/11			
	SURVEY UNDER: 2000 New			
	FACILITY TYPE: SNF/NF			
	TYPE OF STRUCTURE: One (1) story, Type V (111) Protected			
	SMOKE COMPARTMENTS: Seven (7) smoke compartments.			
	COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (Original Installation 10/04/12)			
	FULLY SPRINKLED, SUPERVISED Two (2) wet and Three (3) Dry Systems Original Installation 09/21/12.			
	EMERGENCY POWER: Type II Diesel Generator. (Original Installation 10/03/12)			
	A life safety code survey was initiated and concluded on 09/10/13. 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).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Thomas DHA
TITLE: ED
(X6) DATE: 10-11-13

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.

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

PRINTED: 10/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185470		R 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS AT HAMBURG	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 Offsite Revisit was conducted and determined the facility was deemed to be in compliance as alleged on the acceptable POC of 10/17/13.	{F 000}		

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

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